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ABSTRACT

The stated purpose of this text is to assist supervisors and practicum students and interns in their practicum/internship training. This book contains theoretical components which are valuable and essential to the training of student counselors and psychotherapists. In addition to the theoretical aspects presented, training activities germane and necessary to the development of applied counseling skills are explicated. The text responds to major changes that have taken place in the professional, legal, and ethical aspects of training. The first chapter discusses definitions, phases, and standards for internships. The second and third chapters focus on practicum and internship experiences respectively. The fourth chapter discusses monitoring the interactions with the client. The fifth chapter discusses monitoring the professional development of practicum students and interns. The sixth chapter focuses on ethical and legal guidelines, including standards of the American Association for Counseling and Development, the American Psychological Association, and the National Academy of Certified Mental Health Counselors. The seventh chapter discusses models and methods of consultation in schools and mental health agencies. The eighth chapter discusses recognizing and managing critical client problems. The last chapter includes forms for final evaluation. (ABL)

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# PRACTICUM

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# INTERNSHIP

## Textbook for Counseling and Psychotherapy

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John C. Boylan, Ph.D.
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# PRACTICUM AND INTERNSHIP TEXTBOOK for COUNSELING and PSYCHOTHERAPY

First Edition

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# for
# COUNSELING
# and
# PSYCHOTHERAPY

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# PREFACE

The purpose of this text is to assist supervisors, and practicum students and interns in their practicum/internship training. Practicum and Internship Textbook for Counseling and Psycho therapy contains theoretical components which are valuable and essential to the training of student counselors and psychotherapists. In addition to the theoretical aspects presented, training activities germane and necessary to the development of applied counseling skills are explicated.

In the last ten years, a great many changes have occurred in professional organizations, the ethical codes, and the legal system as related to the practice of counseling. These changes are having an impact on the training of counselors and psychotherapists. This text contains the necessary information and activities to aid supervisors and students in responding to these changes. It also includes theory and guidelines to innovative instructional approaches which are basic to the education of professional counselors and psychotherapists.

Specifically, this text responds to major changes that have taken place in the professional, legal, and ethical aspects of training. In the professional area, we have referred to two accreditation organizations throughout the text. One accreditation organization is the Council for Accreditation of Counseling and Related Educational Programs (CACREP) which is an independent council created by the American Association for Counseling and Development (AACD) and is now recognized by many colleges and universities as the organization which implements the standards of the counseling profession in preparatory programs. Through their efforts the number of credits and consequently the length of time in training has been significantly increased. Counseling students who, immediately after being graduated, wish to sit for certification by the newly created National Board of Certified Counselors (NBCC) must be graduates of counseling programs approved by CACREP. Many changes regarding practicum and internship experiences for counselors also have taken place in response to the CACREP standards. These differences are reflected in the increased number of hours required in the practicum/intern experience, in the expectations and differentiation of functions between practicum and internship experiences, and in the extent and identification of supervisory services. Another accreditation organization is the American Psychological Association which continues to define and influence the standards set for practicum and intern experiences for psychologist preparation programs. In response to these standards, internship sites can apply directly to the certifying board to become APA approved Internship Sites. The standards for each certifying agency are continually updated. This text has been written to respond to current professional standards.

The legal and ethical context in which the practicum student or intern now functions also has changed quite drastically. Today, experienced supervisors and students are often faced with perplexing situations where nuance flourishes relative to their responsibility to themselves, their client, the legal system, and the professional ethical standards. In this text we have included the latest data and theory regarding the legal and ethical responsibilities of supervisors, practicum students, interns, and of the training institution.

In conclusion, we believe that this text will provide an opportunity to orient practicum/intern supervisors, practicum/intern students, and training institutions to their ethical/legal responsibilities. In addition, the text includes instructional guidelines, details and mechanics for initiating and maintaining a practicum or internship, student counselor/client monitoring techniques, guidelines for supervision, evaluation techniques, and ethical legal issues related to selected problem areas in the practice of counseling and psychology.

John C Boylan, Ph.D.

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CHAPTER 1

# DEFINITIONS, PHASES, AND STANDARDS

This text provides an overview of the elements and procedures related to practicum and internship experiences which are an integral part of professional preparation programs in the helping professions. It is written for practicum students and interns, for practicum and intern professors, and for field site supervisors to structure and guide the applied component of professional training programs. Practicum and internship experiences are required in a broad variety of counselor preparation programs in the helping professions. Counseling and psychology training programs and the national associations and accrediting bodies related to these specializations continue to clarify the definitions of practicum and internship within their field experience requirements. They also specify activities and experiences which are appropriate to each component. The trend has been toward an increase in the number of hours required in field experiences and toward more stringent standards of supervision (Hollis & Wantz, 1986).

All involved in the applied training components in counseling and psychology need to examine carefully the expectations they bring to practicum and internship. The practicum and intern professor, the practicum student and/or intern, the site supervisor, and professional accrediting agencies all have expectations that may vary. We have developed a list of questions which are examples of those which could be directed to each source. Students can add to or modify these as they apply to their specific situation.

**Practicum and Internship Professor**

- How do these persons define the knowledge, skills, and activities appropriate to practicum and internship?
- What are the concepts which provide a foundation for the practicum and internship experiences?
- What is the relationship between the professor and the field site? Does the professor provide an active liaison function between the practicum and internship course activities and the field site? How does the professor provide site-based or campus-based supervision and training activities?
- How is the student expected to demonstrate the identified competencies and how are they evaluated? Will the student be retained in practicum until minimal competencies are demonstrated?
- How does the professor view the responsibility for site placement? Is the student's responsibility clearly stated?
- How does the professor view his/her role in the field experience, i.e., instructional leader, evaluator, manager, role model, resource person?

**Practicum Student and Intern**

- What kinds of experiences are expected and needed by the student or intern?
- What approaches are used in supervision?
- Will practicum and internship experiences lead to the appropriate certification and licensing from the state and/or national certification and licensing boards?
- How do the experiences afforded in practicum and internship reflect the breadth and depth of professional counseling and psychology? Will both individual and

group counseling or therapy be part of the experience?

- With what range of clients can the student expect to work? Are these clients representative of the client population with whom the student expects to work when employed?
- Who are the other practicum students and interns? What kinds of experiences and points of view might they add to group supervision sessions?
- How will the student be evaluated and what kinds of records of counseling or therapy practice (written or taped) will be expected?
- What are the procedures for placement in practicum and internship? What field placement sites are recommended and available?
- Are practicum students and interns expected to have their own insurance?

### Practicum and Internship Site Supervisors

- What are the credentials and experiences of the site supervisors? What are their views on professionalism? Are they active or inactive in professional organizations?
- How does the site supervisor define the role of practicum student or intern? How much time is expected for record keeping, report writing, and case conferences? How much time each week will the supervisor devote to supervision and/or interaction with practicum student or intern?
- How does the site supervisor interact and communicate with the university training program?
- Has the site had previous experience with practicum students and interns?

### Standards Set by Professional Organizations, Certifying Boards, and Accrediting Agencies and University Units

- How many hours of practicum or internship are required in the program and what number of these hours is spent in direct service? What is the ratio of direct service to supervision?
- What kinds of supervisory support are required? Are both individual and group supervision recommended? How many hours of supervision are needed?
- What kinds of procedures apply for the protection of clients? How are the clients about practicum students and interns?
- What are the prerequisites to an internship? How is it placed in the program?
- What number of credit hours are devoted to practicum and internship?

## DEFINITIONS

A few terms must be defined to promote a clear understanding of the meanings intended in this text.

**Counselor:** graduate student in either counselor or psychologist preparation programs which require field based training experiences as part of the curriculum.

**Practicum Student:** a student in training who is enrolled in a specific practicum course.

**Intern:** a student in training who has completed the academic and experiential prerequisites for an internship in a counseling or psychology specialization and is enrolled in the internship component of the program.

**Student:** a term used in certain places in this manual to refer to the person enrolled in either practicum or internship.

**Practicum Site Supervisor:** the person at the field site who shares or has primary responsibility for supervision of the practicum student at the site.

**Practicum/Internship Professor:** the agent of the university (generally a university faculty member) who is directly responsible for the university course in practicum or internship to which the student is assigned.

**Practicum Site:** the place where the practicum experiences occur. The site may be within the university, i.e., counseling practicum clinic or counseling center. The site may be within a school or community agency, i.e., correctional clinic, diagnostic center, mental health center, employment agency, hospital, pastoral counseling agency, or rehabilitation agency.

**Internship Site:** The place where the internship experiences occur. The site meets the university training program's standards for internship experiences and provides the intern with the opportunity to perform all the activities that a regularly employed staff member who occupies the professional role to which the intern is aspiring would be expected to perform. It may be within a school, university, or community agency.

**Internship Site Supervisor:** a clearly designated professional staff member at the internship site who is directly responsible for providing systematic, intensive on-site supervision of the intern's professional training activities and performance. The internship supervisor has professional credentials appropriate to the role to which the intern aspires.

## PHASES OF PRACTICUM AND INTERNSHIP

Judith Scott

Phases of practicum and internship can be described from a number of perspectives. For example, one might describe the practicum and internship from the categories of level of skill such as beginner level, intermediate level, and advanced level. Another way of categorizing phases might be according to functions: such as stating goals, acquiring knowledge, and refining skills and techniques. The author prefers to describe the phases in practicum and internship from a developmental perspective.

Several principles regarding development can be identified within practicum and internship:

1. Movement is directional and hierarchial. Early learnings establish a foundation for later development.
2. Differentiation occurs with new learning. Learning proceeds from the more simplistic and straightforward toward the more complex and subtle.
3. Separation/individuation can be observed. The learning process leads to progressively more independent and separate functioning on the part of the counselor/therapist.

These developmental principles can be identified within the program structure, the learning process, and the supervisory interactions encountered by the trainee.

### Development Reflected in Program Structure

Students can generally expect to proceed through the experiential component of their training programs in an orderly and sequentially planned progression. A typical sequence would be as follows:

Pre-Practicum
└→ Practicum
└→ Internship
└→ Full Professional Status

Some variation exists in counseling and psychology training programs regarding the number of hours required in each component. Also some variation exists in training programs regarding the range of expected skills and competencies which are necessary before the student can move on to the next component in the field experience.

At the pre-practicum end of the continuum, the student could appropriately expect more instructional and active participation with the professor. Basic skill development, and role-playing, peer interaction, and observation activities in a counseling lab setting may be emphasized. In the practicum component, the student is likely to be functioning in a field site with supervision and supportive instructional functions being provided by both university faculty and field site supervisor(s). Observation of functioning professionals at the field site, co-leading counseling activities, and initial contact with a limited range of clients are likely activities in the initial stages of practicum. These activities are gradually expanded to include counseling/therapy with a broader range of clients and increased opportunities to expand and develop the full range of professional behaviors. At the internship end of the continuum the student is expected to be able to participate in the full range of professional activities within the field site under supervision primarily directed by approved field site personnel.

### Development Reflected in Learning Processes

A sequence in the learning process engaged in by the counselor or therapist in training has been described by Hogan (1964). The trainee is characterized as progressing across four levels of development in his/her learning to function in a clinical setting. At Level 1, the trainee is heavily influenced by method or technique and most likely will function out of an imitative or recipe oriented approach to counseling or therapy. At Level 2, the trainee is less method-bound and is primarily concerned with investing and using his/her own personality in the counseling or therapy work. Developing insight and differentiating personal reactions from client realities are recurring struggles in the learning process. At Level 3, the trainee is more able to assume a peer relationship with other professionals and has greater and more stable insight into professional and personal concerns. At Level 4, the trainee approaches the master level and functions independently and/or with consultation to use his/her capacity to bring full range of personal insight and creativity to the counseling or therapy work.

As the trainee progresses across the four levels, the role of counselor or therapist becomes more internalized and integrated. At the initial levels, counseling role and professional behaviors are viewed as being taken in and learned from the outside. At the higher levels of learning, the trainee integrates the role of counselor or therapist into his/her personal identity and becomes the one who knows. New methods and techniques are reflected upon, considered and tried rather than merely read about and applied.

In Figure 1.1. is outlined four levels of learning as the trainee progresses.

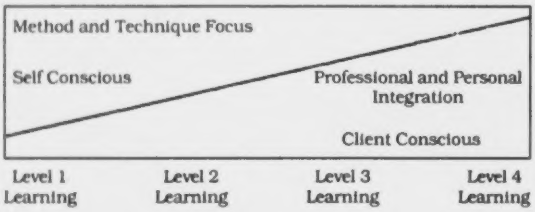

**Figure 1.1.** Schematic outline of trainee across four levels of learning.

### Development Reflected in Supervisory Interaction

The supervisory interaction with the trainee is one which begins with high levels of dependence upon the supervisor for instruction, feedback, and support. The supervisory interaction is modified as skill, personal awareness, and confidence increase for the trainee. The trainee becomes more likely to explore new modes of practice which reflect his/her unique personality and style. The interaction continues to move gradually toward higher levels of independent judgment by the trainee and a more collegial and consultative stance on the part of the supervisor.

In Figure 1.2 is charted the changing balance of trainee and supervisor interaction.

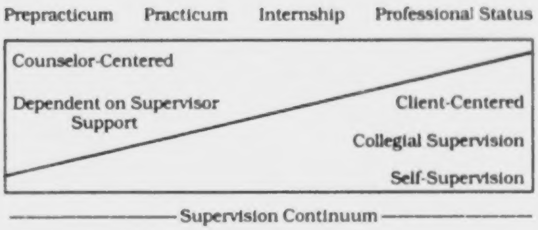

**Figure 1.2.** Schematic representation of trainee-supervisor interaction over time within practicum and internship.

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## STANDARDS FOR PRACTICUM AND INTERNSHIP

Joseph W. Hollis, Ed.D.

Counseling, a profession in transition, is upgrading preparation programs. To do so one must ask, *who* is determining *what* is to be done and *when?* The answer to that question also is changing, however, the picture is becoming clearer—four organizations have gained acceptance and are setting national standards. The acceptance of these standards are not universal; however, they are widely accepted and are having significant impact upon what is offered within counselor preparation programs.

The major experiential components—practicum and internship—have had two major changes in recent years: (1) the amount of time spent in practicum and/or internship and (2) the location (setting) where the experience occurs. A third change is occurring and the anticipation is that the trend will continue—specifications with increased requirements for qualifications of the supervisor doing the clinical supervision of the practicum and/or internship person. These three aspects—clock hours spent, setting, and supervisor qualifications—could make major differences in job opportunities, kind of practice, clientele, philosophical orientation, and techniques emphasized throughout the student's professional life. For these reasons as well as others (i.e., personalities involved, practicum and internship sites available) each student needs to give considerable attention to *where* he/she does practicum and internship, under *whose* clinical supervision, and *when*.

Each of four accreditation bodies (national organizations) has established separate and somewhat different standards—each to meet preparation needs for counselors with particular areas (Hollis & Wantz, 1986, pp. 77-102). Even though perhaps only one of these four is applicable to you, an understanding of all four will assist you in better understanding qualifications of others within the mental health profession with whom you may be co-worker, team member, consulting, or referring clients.

### PROFESSIONAL COUNSELORS

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) met for the first time in September 1981. This independent Council was created by what is now called American Association for Counseling and Development (AACD) and its divisions in order to implement standards of the counseling professions in preparation programs. The Council agreed to honor all previous accreditation decisions having been rendered by the Association for Counselor Education and Supervision (ACES) and those previously made by the California Association of Counselor Education and Supervision (CACES).

CACREP accredits entry level programs at the master's level in three areas: Counseling in Community and other Agency Settings, School Counseling, and Student Personnel Services in Higher Education. At the entry level those statements related to practicum and internship are as follows:

> The program must provide specialized studies necessary for practice in different work settings so that each student may gain skills needed to work effectively in the professional setting where the student plans to practice. Specific counseling practica have sufficient duration and continuity to assure optimum professional development as evidenced through such outcome measures as evaluation ratings by program and site supervisors, assessments by employers, current and former students, and by other performance indicators and qualitative evaluation methods.
>
> Ordinarily, practica will be one quarter time of a work week extended over a minimum of one academic term. Variations should be described and justified in the self-study.
>
> Specific internships have sufficient duration and continuity to assure optimum professional development as evidenced through such outcome measures as evaluation ratings by program and site supervisors, assessments by employers, current and former students, and by other performance indicators and qualitative evaluation methods. It is desirable that the internship be a paid experience.
>
> Ordinarily, internships will be full-time of a work week extended over a minimum of one academic term or half-time of a work week extended over two academic terms. Variations should be described and justified in the self-study.

In summary form related to the three aspects identified as being of primary interest, the following would be applicable:

**Setting**—for Practicum and Internship—in a setting similar to where the student plans to practice.

**Clock Hours Spent—**

**Practicum**—10 hours per week over a minimum of 11 weeks.

**Internship**—40 hours per week over a minimum of 11 weeks or 20 hours per week over a minimum of 22 weeks.

**Supervisor**—site supervisor without other specifications for supervisor credentials.

The credentials of the supervisor are not specified; however, the new proposed guidelines scheduled to be implemented in July, 1988, recommend NCC certification or a degree in counseling or related field. It also recommends an increased number of hours of internship.

CACREP also accredits counselor education programs at the PhD and EdD levels. The statement applicable to practicum and internship is as follows:

> Supervised experiences include the completion of at least 1 academic year (36 weeks) of full time internship.

Implications for setting are same as for entry level master's program. Clock hours spent are clear (40 hours x 36 weeks or 1,440 hours).

## COUNSELING PSYCHOLOGISTS

The American Psychological Association (APA) has for several years accredited programs for preparation of counseling psychologists at the doctoral level only. The accreditation criteria for practicum and internship are as follows:

> Supervised practicum, internship, and field or laboratory training must be included. The minimum practicum experience is 400 hours, of which at least 150 hours are in direct service experience and 75 hours of formally scheduled supervision. Internship

must be full-time for 1 academic or calendar year or the equivalent with an experience of at least 1500 hours. Intensive individual supervision of high quality and ample quantity must be provided with two hours per week as a minimum for formally scheduled individual supervision.

In summary, the site is not specified and neither are the credentials for the supervisor; however, the statement is that the primary emphasis must remain on training by professional psychologists, collaborative work with representatives of other disciplines is desirable. The clock hours are specified. In general the accreditation committee does review practicum and internship sites and the supervisor's credentials.

## MARRIAGE AND FAMILY THERAPISTS

The American Association for Marriage and Family Therapy (AAMFT) through its Commission on Accreditation for Marriage and Family Therapy Education (CAMFTE) serves as an accreditation body for graduate programs and post degree clinical training programs. The major items pertaining to practicum and internship are as follows:

> Supervised clinical practice is expected to involve direct clinical work with couples and families. A minimum of 500 hours of direct clinical contact and 100 hours of clinical supervision are required.
>
> Supervision involves face-to-face conversation between student and supervisor once a week over a period of one or more years. The ratio of supervision hours to treatment hours should never be less than 1 hour of supervision to 5 hours of clinical contact. Peer or more advanced student supervision of another student is unacceptable.

In summary, the points applicable to the three aspects are as follows:

**Setting**—Not specified but implied within a clinical setting.

**Clinical Hours Spent**—500 or more hours of direct clinical contact.

**Supervisor**—Clinical supervision (standards are present for qualifications) with a minimum of 100 hours for 1 year with no less than 1 hour of supervision to 5 hours of clinical contact.

## REHABILITATION COUNSELORS

The Council on Rehabilitation Education (CORE) is the accrediting body for master's degree programs in rehabilitation counselor education. Those statements applicable to practicum and internship are as follows:

> Practicum must be done under supervision with disabled persons and include case conferences, client staffing, plan development, client evaluation, referral, case recording, and caseload management.
>
> Internship is a field work experience in an accredited rehabilitation agency or facility, supervised by a certified rehabilitation counselor and the intern must be involved in professional organization activities.

In summary, the requirements for the three aspects are as follows:

**Setting**—

**Practicum**—Must be with disabled persons

**Internship**—In an accredited rehabilitation agency or facility.

**Clock Hours Spent**—No specifications listed.

**Supervisor**—

**Practicum**—No specifications listed.

**Internship**—Certified rehabilitation counselor

## COUNSELOR CERTIFICATION

Certifying bodies, in addition to accreditation organizations stipulating what is expected within the preparation program, are being more specific about practicum and internship experiences. As a result, counselors-in-preparation need to keep abreast with these requirements and trends so as to obtain those practicum and/or internship experiences that will enable them to be eligible for the certificate(s) they may desire after graduation.

The National Board of Certified Counselors (NBCC) awards the designation of *National Certified Counselor* (NCC) to those applicants who successfully fulfill certain criteria.

> All applicants must provide documentation of successful completion of a supervised practicum or internship. Applicants who have not completed a CACREP-accredited preparation program must also provide documentation of successful completion of a minimum of two years, post-master's degree, professional-counseling experience of at least 20 hours per week. This requirement is waived for graduates of CACREP-accredited programs because of the extensive requirements for supervised counseling experience in the CACREP-accreditation standards. (Vacc & Loesch, 1987, p. 207)

The National Academy for Certified Clinical Mental Health Counselors (NACCMHC) provides a certification appropriate for many professional counselors. One requirement is a minimum of 1500 clock hours of pre-application experience as a mental health counselor supervised by a person with NACCMHC certification or equivalent credentials. The certification status awarded is *Certified Clinical Mental Health Counselor* (CCMHC).

The Commission on Rehabilitation Counselor Certification (CRCC) provides another certification appropriate for many professional counselors. Supervised rehabilitation counseling experience is required. The CRCC awards the designation *Certified Rehabilitation Counselor* (CRC).

The American Association for Marriage and Family Therapy (AAMFT) provides a professional credential entitled *Clinical Member* status. The eligibility criteria include at least 200 hours of supervised work as a marriage and family therapist, and at least 1500 clock hours of pre-application and two years of post-graduate degree professional work experience in marriage and family counseling.

State certification and licensure vary from state to state. However, almost all will stipulate practicum and/or internship and often will stipulate specifications in relation to one or more of the three aspects previously listed: setting, clock hours spent, and supervisor qualifications.

## SUMMARY AND IMPLICATIONS

Practicum and internship, the major experiential components within the preparation program, have changed within recent years and are expected to change even more in the next few years. Those changes could have an important effect upon each graduate's future.

As states establish laws, certification, and licensure boards, the regulations are expected to become more specific in regards to three aspects; (1) settings for these experiences, (2) time spent in these experiences and specific functions performed (e.g., client contract, interaction with supervisor, case conferences, client staffing, plan development, client evaluation, referral, case recording, consulting, and caseload management), and (3) supervisor credentials and time spent between supervisor and student.

Implications for students-in-preparation are becoming very clear. In addition to requirements for practicum and internship as stipulated by the counselor-preparation program, each student in light of his/her own projected future will need to give careful consideration to four items: (1) selection of the site(s) where practicum and/or internship is experienced. (2) review of the credentials of the supervisor. (3) availability of the supervisor to devote considerable time to supervision, and (4) clients normally served in the setting to assure a wide spectrum of experiences comparable to the breadth of the student's potential employment during the next several years.

A personal note may be helpful. Based upon sixteen years of research on counselor preparation throughout the United States, I have watched the changes. In no part of the total preparation program has the change been more significant in what probably will determine a student's future than in the practicum and internship area. Also interestingly, the certification requirements as they develop are being established with more requirements than the standards for graduation. Thus students must look beyond the local college or university requirements and must consider trends in two other areas: certification by professional organizations and licensure/certification requirements.

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# NOTES

CHAPTER **2**

# PRACTICUM EXPERIENCE

Students are required often to complete both a practicum and an internship. In Chapter 1 we have reviewed the definitions and summarized the professional standards which are currently influencing the applied practice components of programs. Chapter 2 focuses on the practicum site and Chapter 3 focuses on the internship site. Current CACREP and APA Guidelines are utilized as much as possible in the format presented. The practicum student or intern and the professor/supervisor may need to make adaptations in the format presented in order to meet particular needs of their institutions and/or setting.

## GUIDELINES FOR CHOOSING A PRACTICUM SITE

The practicum placement is often the first opportunity that the student has to gain experience with working with a client population. Prior counseling experience probably occurred in pre-practicum or practicum lab situations with volunteers or peer counseling interactions. Many counselor preparation programs offer the student an opportunity to have some say in determining the practicum placement. The practicum student may be able to gain experience at more than one practicum site. The university practicum supervisor has the responsibility for deciding where the practicum student might gain the best experiences for professional development given his/her particular needs and professional goals. The practicum site personnel have responsibility to select practicum students whom their professional staff believe will be able to benefit from the placement and serve the needs of the client population. The practicum student can tentatively select sites of interest and then with university supervisor's approval visit and apply for placement. A list of approved sites can be provided by your program.

Going about the selection and application process can be confusing. A helpful procedure is to have criteria in mind as you are considering a practicum placement. The usual categories which are considered in the selection process are personnel available, professional associations of the site, professional practices of the site, administrative support, and other related information. Within these categories the following questions may be helpful in determining selection of a practicum site.

### Personnel

- What are the professional credentials of site personnel? What is the educational background and range of experiences of the director and practicum supervisor?
- What values regarding training and supervision are verbalized and demonstrated?
- Will the supervisor be available for individual supervision for a minimum of one hour a week?
- What are the special counseling/therapy interests of the practicum supervisor(s)?
- Do the staff members regularly update their skills and participate in continuing education?

### Professional Associations of the Site

- In what association does the site hold membership?
- Does the site hold approval of national certifying agencies?
- What is the reputation of the site among other organizations?
- Does the site have affiliations or working cooperations with other institutions?

### Professional Practices

- Does the site follow the ethical guidelines of the profession (APA, AACD, NASW, AAMFT)? Which one(s)?

- What kinds of resources are available to personnel (i.e., library, computer programs, ongoing research, professional consultation)?

- What are the client procedures, treatment modalities, staffing and outreach practices? How are these consistent with goals of practicum?

- How are client records kept? What are their policies and procedures regarding taping (audio and/or video) and other practicum support activities?

- Will practicum students have opportunity for full participation?

**Administration**

- What resources, if any, are directed toward staff development?

- How is policy developed and approved (corporate structure, board of directors, contributors)?

- How stable is the site (hard money or soft money support, length of service of director and staff, purposes or mission statements)?

**Other Information**

- Who is the client population served, i.e., restricted group or open; age range narrow or wide; services remedial, preventive, and/or developmental; social-economic level low, middle, and/or high?

- Are adequate facilities available for practicum students?

- Does the site and its professional staff demonstrate high regard for human dignity and support civil right of clients?

## NEGOTIATING THE PRACTICUM PLACEMENT

After the initial stage has been completed for site selection, the next step is to negotiate the practicum placement. This process works best when a written exchange of agreement is made so that all parties involved in the practicum placement understand roles and responsibilities involved. Specific guidelines followed in the practicum can be stated as part of the agreement. Guidelines identified by national certifying agencies are often used or referenced in formalizing the practicum placement.

In APA practicum guidelines, statements concerning the development of the following capacities are included:

- understanding of and commitment to professional and social responsibility as defined by statutes of the ethical code of the profession [see Chapter 5 of this manual],

- the capability to conceptualize human problems,

- awareness of the full range of human variability among the dimensions of ethnicity, sub-culture, affirmative action, race, religion, sexual preference, handicap, sex, and age,

- understanding of one's own personality and biases and of one's impact upon others in professional interaction,

- skill in relevant interpersonal interactions such as systematic observation of behavior, interviewing, psychological testing, psychotherapy, counseling and consultation, and

- ability to contribute to current knowledge and practice.

In CACREP guidelines, the development of basic individual (and possibly group) counseling skills is recommended. Statements related to practicum activities include

- experience in individual (and possibly group) interaction with clientele appropriate to the program emphasis,

- familiarizing students with a variety of professional activities other than direct service work,

- use of a variety of professional resources such as measurement instruments, computers, print and non-print media, professional literature, and research.

State Licensing Board and state Departments of Education also may provide guidelines and set standards regarding field experience activities and minimum number of hours required in practicum. In addition, University and program faculty may have their own guidelines. We suggest that the counselor preparation program identify the guidelines which it follows and include the guidelines in the practicum contract.

Many counselor preparation programs exchange a formal agreement with the field site in the placement of practicum students. A *Sample Letter* (Sample 1) and contract (Form 2.1) are included which can be adapted to the specific needs of your training program. The contract includes a statement concerning guidelines to be followed, conditions agreed upon by the field site, conditions agreed upon by the counselor or psychologist preparation program, and a list of practicum activities.

## ROLE AND FUNCTION OF THE PRACTICUM STUDENT

The practicum student, who has been accepted to the field site, will start as a novice in the counseling profession; however, he/she will be a representative of the University and other student counselors or psychologists. The student is working in the setting as a guest of the practicum site. The site personnel have agreed to provide the student with appropriate counseling experiences with the clientele they serve. Although the individual freedom of the student counselor is understood and respected, the overriding concern of the site personnel is to provide role appropriate services to the client population. The role of the practicum student is to obtain practice in counseling or psychotherapy in the manner in which it is provided in the practicum setting. The student counselor is expected to adhere to any dress codes or expected behaviors which are existent at the field site. In some instances the student may disagree with some of the site requirements, however the role of the student counselor is not to change the system but to develop his/her own abilities in counseling practice. Privileges extended to the student counselor may be revoked by the site staff at its own discretion.

If conflicts arise between the student counselor and the site personnel, this can provide the student with a good opportunity to develop personal insight. The first order of work for the student is to reflect on what about self makes this situation problematic rather than to focus upon what about the system is flawed. The faculty liaison is always available to assist the student in the process of understanding self in the system and to facilitate the student's ability to function in the setting. When the student counselor is accepted into practicum, he/she enters into an agreement with the site and the University regarding expected professional behaviors.

A *Student Profile Sheet* (Form 2.2) and a *Letter of Agreement* (Form 2.3) have been included. The Student Profile Sheet guides the documenting of the student counselor's academic preparation and relevant experience prior to practicum. The Letter of Agreement demonstrates a formal agreement being entered into by the student.

## CONCEPTS IN PRACTICUM

Concepts about the practicum experience influences the kinds and range of activities, the process of supervisory and consulting interaction, and the nature of the teaching contract between the Practicum student and the professor. Such concepts provide the foundation of this beginning experiential component of professional training. Although no one right way exists to develop a conceptual framework for practicum, the practicum professor must be able to articulate the framework and to share this with the student.

The following example represents a possible conceptual framework. It can be used as a reference for the practicum professor who is structuring the practicum with the students. Some concepts may be used as a point of departure for discussion; others may be modified; and others may be challenged.

(Continued on p. 25.)

Sample Letter

(Use University Stationery)

Date

Dear Practicum Site Supervisor,

The enclosed contract is designed to formalize the arrangement between ______________________________ (University Program) and ______________________ (Practicum Site) for student counselors enrolled in the practicum at ______________ ____________________(University.) The practicim activities have been selected based upon APA and CACREP Guidelines,State Licensing or Certification requirements,and the University and Program faculty recommendations.

If the guidelines, agreements, and practicum activities are followed closely, the student counselor should have the opportunity to demonstrate counseling competencies at an increasing level of complexity in the amount of time contracted. We realize that a practicum site may not be able to provide access for the student to every activity because of the differences which exist in individuals and institutions. The contract for each practicum experience will indicate those activities that can be provided.

We appreciate and thank you for your interest and co-operation in helping to prepare professional counselors/psychologists.

Sincerely,

_________________________
(Name of Professor)
Ph.# ______________

**Sample 1.** Letter sent to practicum site supervisor.

## PRACTICUM CONTRACT

This agreement is made on ____________________ (date) by and between ____________________ (Field Site)

and ________________________________________ (University Program). The agreement will be effective for

a period from ______________ to ______________ for ______________ (no. hours.) per week for

________________________________________ (Student name).

**Purpose:**

The purpose of this agreement is to provide a qualified graduate student with a practicum experience in the field of counseling/psychology.

**The University Program agrees:**

1. to assign a University faculty liaison to facilitate communication between University and site;
2. to provide the site prior to placement of the student the following information
   a. profile of the student named above and
   b. an academic calendar which shall include dates for periods during which student will be excused from field supervision;
3. to notify the student that he/she must adhere to the administrative policies, rules, standards, schedules, and practices of the site;
4. that the faculty liaison shall be available for consultation with both site supervisors and students and shall be immediately contacted should any problem or change in relation to student, site, or University occur; and
5. that the University supervisor is responsible for the assignment of a fieldwork grade.

**The Practicum Site agrees:**

1. to assign a practicum supervisor who has appropriate credentials, time, and interest for training the practicum student;
2. to provide opportunities for the student to engage in a variety of counseling activities under supervision and for evaluating the student's performance (suggested counseling experiences included in the Practicum Activities);
3. to provide the student with adequate work space, telephone, office supplies, and staff to conduct professional activities.

4. to provide supervisory contact which involves some examination of student work using audio/visual tapes, observation, and/or live supervision; and

5. to provide written evaluation of student based on criteria established by the University Program.

With the specified time frame, ______________________________

(Site Supervisor) will be the primary practicum site supervisor. The training activities (checked below) will be provided for the student in sufficient amounts to allow an adequate evaluation of the student's level of competence in each activity. ______________________________ will be the faculty liaison with whom the student and practicum site supervisor will communicate regarding progress, problems, and performance evaluations.

## PRACTICUM ACTIVITIES

1. Individual Counseling/Psychotherapy
   - Personal/Social Nature
   - Occupational/Educational Nature
2. Group Counseling/Psychotherapy
   - Co-leading
   - Leading
3. Intake Interviewing
   - Including taking social history information
4. Testing
   - Administration
   - Analysis
   - Interpretation of Results
5. Report Writing
   - Record Keeping
   - Treatment Plans
   - Treatment Summaries
6. Consultation
   - Referrals
   - Professional Team Collaboration
7. Psycho/Educational Activities
   - Parent Conferences
   - Outreach
   - Client Orientation
   - Contact with Community Resources
   - In-service
8. Career Counseling
9. Individual Supervision
10. Group or Peer Supervision
11. Case Conferences or Staff Meetings
12. Other (Please list) ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Practicum Site Supervisor: ______________________________ Date: __________

Student: ______________________________ Date: __________

Faculty Liaison: ______________________________ Date: __________

## PRACTICUM CONTRACT

This agreement is made on ______________ (date) by and between ______________ (Field Site)

and ______________ (University Program). The agreement will be effective for

a period from ______________ to ______________ for ______________ (no. hours.) per week for

______________ (Student name).

**Purpose:**

The purpose of this agreement is to provide a qualified graduate student with a practicum experience in the field of counseling/psychology.

**The University Program agrees:**

1. to assign a University faculty liaison to facilitate communication between University and site;
2. to provide the site prior to placement of the student the following information
    a. profile of the student named above and
    b. an academic calendar which shall include dates for periods during which student will be excused from field supervision;
3. to notify the student that he/she must adhere to the administrative policies, rules, standards, schedules, and practices of the site;
4. that the faculty liaison shall be available for consultation with both site supervisors and students and shall be immediately contacted should any problem or change in relation to student, site, or University occur; and
5. that the University supervisor is responsible for the assignment of a fieldwork grade.

**The Practicum Site agrees:**

1. to assign a practicum supervisor who has appropriate credentials, time, and interest for training the practicum student;
2. to provide opportunities for the student to engage in a variety of counseling activities under supervision and for evaluating the student's performance (suggested counseling experiences included in the Practicum Activities);
3. to provide the student with adequate work space, telephone, office supplies, and staff to conduct professional activities.

4. to provide supervisory contact which involves some examination of student work using audio/visual tapes, observation, and/or live supervision; and

5. to provide written evaluation of student based on criteria established by the University Program.

With the specified time frame, ______________________________ (Site Supervisor) will be the primary practicum site supervisor. The training activities (checked below) will be provided for the student in sufficient amounts to allow an adequate evaluation of the student's level of competence in each activity. ______________________________ will be the faculty liaison with whom the student and practicum site supervisor will communicate regarding progress, problems, and performance evaluations.

## PRACTICUM ACTIVITIES

1. Individual Counseling/Psychotherapy
    - Personal/Social Nature
    - Occupational/Educational Nature
2. Group Counseling/Psychotherapy
    - Co-leading
    - Leading
3. Intake Interviewing
    - Including taking social history information
4. Testing
    - Administration
    - Analysis
    - Interpretation of Results
5. Report Writing
    - Record Keeping
    - Treatment Plans
    - Treatment Summaries
6. Consultation
    - Referrals
    - Professional Team Collaboration
7. Psycho/Educational Activities
    - Parent Conferences
    - Outreach
    - Client Orientation
    - Contact with Community Resources
    - In-service
8. Career Counseling
9. Individual Supervision
10. Group or Peer Supervision
11. Case Conferences or Staff Meetings
12. Other (Please list) ______________

Practicum Site Supervisor: ______________________________ Date: ____________

Student: ______________________________ Date: ____________

Faculty Liaison: ______________________________ Date: ____________

# PRACTICUM CONTRACT

This agreement is made on ____________________ (date) by and between ____________________ (Field Site)

and ______________________________ (University Program). The agreement will be effective for

a period from ______________ to ______________ for ______________ (no. hours.) per week for

______________________________ (Student name).

**Purpose:**

The purpose of this agreement is to provide a qualified graduate student with a practicum experience in the field of counseling/psychology.

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3. to notify the student that he/she must adhere to the administrative policies, rules, standards, schedules, and practices of the site;
4. that the faculty liaison shall be available for consultation with both site supervisors and students and shall be immediately contacted should any problem or change in relation to student, site, or University occur; and
5. that the University supervisor is responsible for the assignment of a fieldwork grade.

**The Practicum Site agrees:**

1. to assign a practicum supervisor who has appropriate credentials, time, and interest for training the practicum student;
2. to provide opportunities for the student to engage in a variety of counseling activities under supervision and for evaluating the student's performance (suggested counseling experiences included in the Practicum Activities);
3. to provide the student with adequate work space, telephone, office supplies, and staff to conduct professional activities.

Form 2.1, p.1 of 2, Copy 3

4. to provide supervisory contact which involves some examination of student work using audio/visual tapes, observation, and/or live supervision; and
5. to provide written evaluation of student based on criteria established by the University Program.

With the specified time frame, ______________________________

(Site Supervisor) will be the primary practicum site supervisor. The training activities (checked below) will be provided for the student in sufficient amounts to allow an adequate evaluation of the student's level of competence in each activity.. ______________________________ will be the faculty liaison with whom the student and practicum site supervisor will communicate regarding progress, problems, and performance evaluations.

## PRACTICUM ACTIVITIES

1. Individual Counseling/Psychotherapy
    - Personal/Social Nature
    - Occupational/Educational Nature
2. Group Counseling/Psychotherapy
    - Co-leading
    - Leading
3. Intake Interviewing
    - Including taking social history information
4. Testing
    - Administration
    - Analysis
    - Interpretation of Results
5. Report Writing
    - Record Keeping
    - Treatment Plans
    - Treatment Summaries
6. Consultation
    - Referrals
    - Professional Team Collaboration
7. Psycho/Educational Activities
    - Parent Conferences
    - Outreach
    - Client Orientation
    - Contact with Community Resources
    - In-service
8. Career Counseling
9. Individual Supervision
10. Group or Peer Supervision
11. Case Conferences or Staff Meetings
12. Other (Please list) ______________________________

Practicum Site Supervisor: ______________________________ Date: ____________

Student: ______________________________ Date: ____________

Faculty Liaison: ______________________________ Date: ____________

# STUDENT PROFILE SHEET

**Directions:** Student counselor is to submit this information in duplicate to the University practicum liaison who will submit a copy to the field site.

Practicum Student Counselor

Name: ______________________________

Address: ______________________________

Telephone: **Home:** ______________

**Office:** ______________

Date: __________

I hold the degree of ______________________________ from ______________________________ and have completed the following courses as part of the ______________________________ (degree) program with a major in ______________________________ from ______________________________.

Psychology of Human Development ______________

Psychology of Learning ______________

Counseling Skills ______________

Intro to Counseling ______________

Theories of Counseling ______________

Other (Please List):

______________________

______________________

______________________

Tests & Measurements ______________

Personality Development ______________

Career Development ______________

Legal & Ethical Issues ______________

Process & Techniques of Group Counseling ______________

______________________

______________________

______________________

Professional and Non-Professional Work Experience:

# STUDENT PRACTICUM/INTERNSHIP AGREEMENT

**Directions:**

Student is to complete this form in duplicate and submit a copy of this agreement to the University practicum supervisor or internship coordinator.

1. I hereby attest that I have read and understood the American Psychological Association and the American Association for Counseling and Development ethical standards [Chapter 5 in this manual] and will practice my counseling in accordance with these standards. Any breach of these ethics or any unethical behavior on my part will result in my removal from practicum/internship, a failing grade, and documentation of such behavior will become part of my permanent record.

2. I agree to adhere to the administrative policies, rules, standards, and practices of the practicum/internship site.

3. I understand that my responsibilities include keeping my practicum/internship supervisor(s) informed regarding my practicum/internship experiences.

4. I understand that I will not be issued a passing grade in practicum/internship unless I demonstrate the specified minimal level of counseling skill, knowledge, and competence and complete course requirements as required.

**Signature:** ______________________________

**Date:** ______________________________

Form 2.3, p.1 of 1, Copy 1

# STUDENT PROFILE SHEET

**Directions:** Student counselor is to submit this information in duplicate to the University practicum liaison who will submit a copy to the field site.

Practicum Student Counselor

Name: ______________________

Address: ______________________

Telephone: **Home:** ____________

**Office:** ____________

Date: __________

I hold the degree of ______________________ from ______________________ and have completed the following courses as part of the ______________________ (degree) program with a major in ______________________ from ______________________.

Psychology of Human Development ____________

Psychology of Learning ____________

Counseling Skills ____________

Intro to Counseling ____________

Theories of Counseling ____________

Tests & Measurements ____________

Personality Development ____________

Career Development ____________

Legal & Ethical Issues ____________

Process & Techniques of Group Counseling ____________

Other (Please List):

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Professional and Non-Professional Work Experience:

# STUDENT PRACTICUM/INTERNSHIP AGREEMENT

**Directions:**

Student is to complete this form in duplicate and submit a copy of this agreement to the University practicum supervisor or internship coordinator.

1. I hereby attest that I have read and understood the American Psychological Association and the American Association for Counseling and Development ethical standards [Chapter 5 in this manual] and will practice my counseling in accordance with these standards. Any breach of these ethics or any unethical behavior on my part will result in my removal from practicum/internship, a failing grade, and documentation of such behavior will become part of my permanent record.
2. I agree to adhere to the administrative policies, rules, standards, and practices of the practicum/internship site.
3. I understand that my responsibilities include keeping my practicum/internship supervisor(s) informed regarding my practicum/internship experiences.
4. I understand that I will not be issued a passing grade in practicum/internship unless I demonstrate the specified minimal level of counseling skill, knowledge, and competence and complete course requirements as required.

**Signature:** ______________________________

**Date:** ______________________________

Form 2.3, p.1 of 1, Copy 2

1. Practicum is a highly individualized learning experience in which the practicum student is met at the level of personal development, knowledge, and skills which he/she brings to the experience.

In any group of practicum students, one can expect a wide range of talents, unique perspectives regarding human behavior and varying capacities to perceive accurately and engage emotional content. One function of the practicum professor is to role model the optimal facilitative behavior to support the growth and development of students to increase the level of role function. This process parallels the counseling or therapy process. The practicum professor has a unique opportunity to demonstrate respect for the learner as an individual with a unique set of meanings who is capable of accepting responsibility for his/her own learning. The student has the responsibility to bring in material about his/her counseling practice and to share concerns related to practice. The practicum professor and student are partners-in-learning.

2. Practicum facilitates an understanding of one's self, one's biases, and one's impact upon others.

Counseling or therapy is an enterprise which has at its core the assumption that individuals develop by a process of differentiating self from other. It may be viewed as the process of bringing more of one's experiences into the conscious domain. It may be viewed as being able to determine what is my problem and what is your problem. It may be viewed as challenging thinking patterns inappropriately imposed on experience. Whatever the theoretical orientation of the counseling work, the practicum student must examine, on a personal level, the qualities about himself/herself which may enhance or impede this work. The practicum experience provides a setting in which personal qualities related to counseling practice can be examined. Therefore, activities which help clarify the counselor's own feelings, values, background, and perceptions in the context of the counseling work are an appropriate and necessary part of the practicum experience. Focus in practicum is not only directed toward determining the dynamics and personal meanings of the client but also upon examining how the student views others and how his/her behaviors and attitudes effect others.

3. Each member of a practicum group is capable of and responsible for facilitating professional growth and development.

The practicum experience usually involves dyadic, individual, and group activities designed to enhance the quality of counseling practice. Usually peer counseling and peer feedback are selected training activities. Also, usually the group interaction provides a forum in which the practicum members can give and receive feedback regarding counseling techniques and concerns. Each member of the practicum participates not only as a student but also as someone who is able to provide valuable feedback to others regarding the impact particular responses and attitudes may make upon clients. The practicum professor is not the only credible source of feedback regarding student counseling behaviors but rather only one among many responses to be examined. The practicum experience, therefore tends to be more member-centered than leader-centered.

4. Practicum is composed of varied experiences to be determined by the particular needs, abilities, and concerns of the practicum group members and the practicum professor.

Two conditions contribute to the variety and kinds of learning activities which are part of practicum. First, program considerations about how the practicum is placed within the overall curriculum are influential. In some programs basic skill training is an integral part of practicum. In other programs skill training activities are included in other courses. Some programs require more hours of field experience and the practicum is followed by an extensive internship. While in others, the practicum is the only experiential component in the program.

A second condition influencing the kinds and variety of experiences included in practicum is the unique needs which the student brings to the group. These may be personal concerns of the student or concerns related to client needs brought back to the practicum class for discussion. Therefore practicum, by necessity, must have a flexible and formative approach to planning learning activities.

A range of activities which are often included as part of the practicum could be

- —structured skill development exercises
- —unstructured group interaction
- —role playing
- —peer counseling, taping, and critiquing
- —selected assigned readings regarding special problem areas
- —keeping personal journals
- —video-taping and observing counseling sessions
- —giving and receiving feedback
- —preparing case presentations for review
- —interacting with supervisor

5. Supervision and consultation form the central core of practicum.

Intensive supervision and consultation allow the student to move more quickly toward competence and mastery in counseling or therapy. The supervisory interaction can help bring obstacles to the counseling process to awareness so that they can be examined and modified. The supervisory interaction also provides the opportunity for the role modeling process to be strengthened.

The student can usually expect both intensive one-to-one supervision and regular group supervision to be a standard part of the practicum. This provides not only skill development opportunities but also implicitly guides the counselor or therapist toward an openness and appreciation for collegial supervision and self supervision.

6. Self assessment by student and practicum professor is essential.

Because of the flexible and formative nature of the practicum, regular reviews need to be made as to how the practicum experiences are meeting the learning needs of the student. Self assessment allows the student to be consciously aware of and responsible for his/her own development and also provides information for the practicum professor in collaborating about appropriate practicum activities.

The format for this self assessment can be structured in a variety of ways. One possible approach is to identify current strengths, current weaknesses, and current concerns or confusions. The assessments should be defined as concretely as possible. Once the assessment of current functioning is described, a contract can be made with the practicum professor and other group members regarding the particular aspects of counseling practice which have been targeted by the student for improvement or development. Ongoing self assessment is needed to give direction to the practicum.

7. Evaluation is an integral and ongoing part of the practicum.

Evaluation in practicum provides both formative and summative information about how the counseling development goals of the student and practicum professor are being reached. A variety of activities supports this evaluation process. Among these are self-assessment, peer evaluations, regular feedback activities, practicum site supervisor ratings and audio and video-tape review. The attitude from which evaluations are offered is characterized by a constructive coaching perspective rather than a critical judgmental perspective.

## SUGGESTED COURSE REQUIREMENTS

The practicum has been described as a complexly interwoven set of counseling practices and support activities designed to promote skill development, personal growth, and application of knowledge on the part of the trainee. Activities entered into at the practicum site are directed and monitored by the practicum supervisor based upon site opportunities and student abilities. During the first week of activities, the usual emphasis is on orientation to site policies and practice, observation of professional activities, and review of client records and treatment plans in preparation for counseling practice. As the practicum progresses through the several weeks, activities are gradually expanded to include intake interviewing, testing, new client orientation, coleading, and contacts with referral sources. Individual counseling sessions are increased, group work and outreach are added, and the student participates in in-service and case conferences. In the final weeks of practicum, experiences include individual and group counseling or psychotherapy and consultation and referrals.

In addition to actual site-based counseling practice, course requirements are designed to support and monitor the evolving skill plus personal and knowledge bases of the student.

### Class Meetings

Practicum students are generally expected to spend a minimum of two hours per week in a group session with the University supervisor. This time can include didactic and experiential activities and usually includes some form of review of counseling practices. A typical class session would begin by addressing any specific concerns a student has regarding his/her field work. After immediate concerns are addressed, student counselors might engage in the following:

1. role play situations encountered in field work,
2. listen to and discuss various recorded counseling sessions,
3. review previously taped counseling sessions made by class members,
4. discuss theories and techniques related to common problems and client work of concern to group members, and/or
5. give and receive feedback with peers regarding personal and professional interaction.

### Counseling Sessions

In addition to the weekly group meetings, students are required to engage in a specified number of counseling sessions each week. These may be both individual and group sessions. Early in the course the number of sessions required would be less than at the middle and final phases of the course. A specific minimum number of sessions is required for the course. One-time sessions with clients as well as continuing series of sessions with a client are specified.

### Individual Supervision Sessions

The student is expected to spend a minimum of 1 hour per week throughout the length of the course in individual supervision with site and/or university supervisors. These meetings provide an intensive focus on the student's counseling/therapy work and are often regarded by the student counselor as one of the most valuable practicum components. Typical questions addressed during individual sessions include the following: Is the student counselor providing a facilitative interaction with the client? Is the student counselor accurately perceiving the client? What are the goals of the counseling process? Is the counselor able to facilitate the desired growth or change in the client? What obstacles may be present in the counseling work?

### Tape Critiques

If at all possible, the student is expected to tape (audio and/or video) his/her counseling sessions. Of course, permission must be obtained from each client prior to taping the session. The practicum site will have policies and procedures which are to be followed to ensure the informed consent of the client. [See Form 4.2 in Chapter 4 of this manual.] The tapes are to be submitted weekly to the practicum supervisor and/or university supervisor to allow for sharing and evaluation.

Each tape should be reviewed by the student counselor prior to submission and be accompanied by a written or typed critique. The critique should consist of the following information:

1. student counselor name;
2. client identification, number of the session with client;
3. brief summary of content of the session and intended goals;
4. comment regarding the positive aspects of the counselors work during the session;
5. comment regarding the areas of the counselor's work which need improvement;
6. concerns, if any, regarding client dynamics; and
7. plans for further counseling with the client.

Every effort must be taken to ensure the confidentiality of the counseling session. When the tape has been reviewed and discussed with the student counselor, appropriate notes regarding counseling performance can be made for the student's records. The tape(s) then should be erased.

An example of a completed *Tape Critique Form* is shown in Sample 2 for your review and reference. Several blank *Tape Critique Forms* (Form 2.4) have been included for your use.

## DOCUMENTING PRACTICUM ACTIVITIES

Because of national accreditation guidelines and state and University requirements, a necessary procedure is to document both the total number of hours in practicum and the total number of hours spent in particular practicum activities. Two forms are provided for your use. The Weekly Schedules (Form 2.5) which are included can be used in two ways. First, the Weekly Schedule can be used by the practicum student and the practicum supervisor to plan the activities the student will be doing from week to week. Second, the Weekly Schedule can be used to document the weekly activities the student has completed.

The Monthly Practicum Log (Form 2.6) provides a summary of the number of hours work per month in which the student has engaged within the activity categories established in the practicum contract. A file can be kept for each student for the duration of the practicum.

# TAPE CRITIQUE FORM

(Sample)

Jane Smith

Student Counselor's Name

Tom D. session #3

Client I.D. & No. of Session

Brief summary of session content: Tom is citing his reasons for being unhappy in his job situation and reviewing all he has attempted to do to to make his boss like and respect his work.

Intended goals: 1. To help Tom explore all of his feelings and experiences related to the job situation.

2. To help Tom be able to assess and value his work from his own frame of reference rather than his boss's.

Comment on positive counseling behaviors: I was able to accurately identify Tom's feelings and to clarify the connection of feelings to specific content.

Comment on areas of counseling practice needing improvement: I sometimes became hooked into Tom's thinking about how to please his boss and would work with him about problem-solving in this way.

Concerns or comment regarding client dynamics:

Plans for further counseling with this client: Continue weekly appointments; move focus back onto the client and try to identify other ways he worries about approval.

Tape submitted to: Dr. Judith Scott

Date: 4/13/87

**Sample 2.** An example of a completed Tape Critique Form (Form 2.4)

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

# TAPE CRITIQUE FORM

________________________________________

Student Counselor's Name

________________________________________

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to: ______________________________

Date: ______________________________

Form 2.4, p.1 of 1, Copy 3

# TAPE CRITIQUE FORM

______________________________
Student Counselor's Name

______________________________
Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to: ______________________________

Date: ______________________________

Form 2.4, p.1 of 1, Copy 4

# TAPE CRITIQUE FORM

________________________________________

Student Counselor's Name

________________________________________

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to: ________________________________

Date: ________________________________

Form 2.4, p.1 of 1, Copy 5

# TAPE CRITIQUE FORM

________________________________________
Student Counselor's Name

________________________________________
Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to: ________________________________

Date: ________________________________

Form 2.4, p.1 of 1, Copy 6

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

Form 2.4, p.1 of 1, Copy 8

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

# TAPE CRITIQUE FORM

Student Counselor's Name

Client I.D. & No. of Session

Brief summary of session content:

Intended goals:

Comment on positive counseling behaviors:

Comment on areas of counseling practice needing improvement:

Concerns or comment regarding client dynamics:

Plans for further counseling with this client:

Tape submitted to:

Date:

Form 2.4, p.1 of 1, Copy 10

# WEEKLY SCHEDULE

**(Sample)**

| Day of Week | Location | Time | Practicum Activity | Comment |
|---|---|---|---|---|
| Mon | UCC | 9-10 | Intake Interview<br>John W. | 1st session<br>Prob Exploration |
| | | 10-11 | Ind. Cnslg.<br>Jane D. | 5th session; taped<br>personal/social |
| | | 11-12 | Ind. Supervision | Reviewed reports<br>Tape Critique |
| | | 1-3 | Group Cnslg.<br>Co-lead | Eating Disorder Group<br>3rd Session |
| | | 3-4 | Report Writing | |
| | | 4-5 | Testing<br>Mary B. | Interpreted Strong/Campbell |
| Wed | University | 6-8 | Group Supervision | Case Presentation<br>Jane D. |

Student Counselor Name: Jane Smith

Week beginning: 4/10/87 Ending: 4/17/87

**Sample 3.** Example of a completed weekly schedule (Form 2.5)

# WEEKLY SCHEDULE

| Day of Week | Location | Time | Practicum Activity | Comment |
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Student Counselor Name: ______________________

Week beginning: __________ Ending: __________

Form 2.5, p.1 of 1, Copy 1

# WEEKLY SCHEDULE

| Day of Week | Location | Time | Practicum Activity | Comment |
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Student Counselor Name: ____________________

Week beginning: __________ Ending: __________

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Week beginning: ______________ Ending: ______________

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Week beginning: ____________ Ending: ____________

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Student Counselor Name: ____________________

Week beginning: __________ Ending: __________

Form 2.5, p.1 of 1, Copy 6

# WEEKLY SCHEDULE

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Student Counselor Name: ______________________________

Week beginning: ____________ Ending: ____________

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Student Counselor Name: ______________________________

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Student Counselor Name: ______________________________

Week beginning: ____________ Ending: ____________

Form 2.5. p.1 of 1. Copy 9

# WEEKLY SCHEDULE

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Student Counselor Name: ____________________

Week beginning: ____________ Ending: ____________

# WEEKLY SCHEDULE

| Day of Week | Location | Time | Practicum Activity | Comment |
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Student Counselor Name: ______________________________

Week beginning: ____________ Ending: ____________

Form 2.5, p.1 of 1, Copy 11

# WEEKLY SCHEDULE

| Day of Week | Location | Time | Practicum Activity | Comment |
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Student Counselor Name: ______________________

Week beginning: ____________ Ending: ____________

Form 2.6. p.1 of 1. Copy 1

## MONTHLY PRACTICUM LOG

Name: ______________________

Practicum Supervisor: ______________________
(Signature)

Practicum Site: ______________________

| Month of | Intake Interview | Ind. Counseling | Group Counseling | Testing | Report Writing | Consultation | Psycho-Educational | Career Counseling | Case Conference | Other (Specify) |
|---|---|---|---|---|---|---|---|---|---|---|
| Week 1<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 2<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 3<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 4<br>Dates:<br>Total Hours: | | | | | | | | | | |

# MONTHLY PRACTICUM LOG

Name: ______________________________

Practicum Supervisor: ______________________________
(Signature)

Practicum Site: ______________________________

| Month of | Intake Interview | Ind. Counseling | Group Counseling | Testing | Report Writing | Consultation | Psycho-Educational | Career Counseling | Case Conference | Other (Specify) |
|---|---|---|---|---|---|---|---|---|---|---|
| Week 1<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 2<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 3<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 4<br>Dates:<br>Total Hours: | | | | | | | | | | |

Form 2.6, p.1 of 1, Copy 2

Form 2.6. p.1 of 1. Copy 3

# MONTHLY PRACTICUM LOG

Name: ______________________________

Practicum Site: ______________________________ Practicum Supervisor: ______________________________
(Signature)

| Month of | Intake Interview | Ind. Counseling | Group Counseling | Testing | Report Writing | Consultation | Psycho-Educational | Career Counseling | Case Conference | Other (Specify) |
|---|---|---|---|---|---|---|---|---|---|---|
| Week 1<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 2<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 3<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 4<br>Dates:<br>Total Hours: | | | | | | | | | | |

# MONTHLY PRACTICUM LOG

Name: ______________________________

Practicum Supervisor: ______________________________
(Signature)

Practicum Site: ______________________________

| Month of | Intake Interview | Ind. Counseling | Group Counseling | Testing | Report Writing | Consultation | Psycho-Educational | Career Counseling | Case Conference | Other (Specify) |
|---|---|---|---|---|---|---|---|---|---|---|
| Week 1<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 2<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 3<br>Dates:<br>Total Hours: | | | | | | | | | | |
| Week 4<br>Dates:<br>Total Hours: | | | | | | | | | | |

CHAPTER 3

# INTERNSHIP EXPERIENCE

In Chapter 2 is addressed the training and program requirements of practicum activities both on and off campus. Emphasis was placed upon the university training program assuming responsibility for providing course work and supervision of students.

In Chapter 3 is addressed the internship component of the students training program. Emphasis is placed upon the procedures for evaluating and obtaining internship placement in a school or agency.

This section is based upon the assumption that the student has completed all or almost all formal course work at the training institution and is completing his/her internship experience in an approved internship site. An important concept to note is that the internship experience is typically quite different from previous pre-practicum and practicum experiences. In the internship, the major responsibility for the supervision of the intern is the site supervisor. Thus, the student needs to formalize the relationship with the site supervisor to ensure that the requirements of the internship are consistent with the goals of the institution and the student's personal and professional goals.

This section will provide the student with an overview of what is considered to be the fundamental steps in selecting and evaluating an internship placement.

The transition from practicum to internship can create considerable concern for the student. Selecting an internship site without adequate knowledge of the requirements of both the university training program and the specific internship sites to be considered prevents the student from making an informed decision regarding placement.

Although the selection process may be viewed by some students as an opportunity to explore experiences that are available for training and supervision, often other students feel pressured to make a decision based upon limited information without adequate thought and preparation.

## SELECTION AND EVALUATION OF AN INTERNSHIP SITE

A major issue to be addressed by the perspective intern is the appropriateness of the internship experience in relation to the student's personal and professional goals. A well recognized fact is that the completion of an internship experience that meets the student's career needs and program needs as well as providing good supervision and training enhances the student's professional viability.

The initial step in the selection of an internship site requires the student to gather as much information as possible about each potential internship site and personnel.

In preparation, a number of questions needs to be addressed:

- Will the internship provide me with a wide variety of professional activities in keeping with my training and professional goals?
- Does the internship client/patient population represent the type of population with whom I want to work?
- Will I be exposed to all the activities and experiences that a regularly employed staff member would experience?
- Will I be provided with direct supervision by a trained supervisor?
- Have the internship site personnel had experience in working with interns or is this the first time an intern is placed there?
- Do/will appropriate liaison activities occur between the university training program and the internship site staff?

Answers to these questions enable the student to gain an initial overview of the proposed internship experience at one or more different sites. Consulting with university faculty, the internship coordinator and other professionals are an invaluable source of internship information. Data about the type of setting, the client population, types of services, and the staff size aid in the process of determining if the internship site is in keeping with the student's professional needs. *The Intern Site Pre-Selection Data Sheet* (Form 3.1) included in this chapter can be used to gather appropriate information about the internship site. The information needed to complete the form can usually be obtained by consulting with professionals familiar with the site, by informally visiting the site, or by writing to the site to obtain available descriptive materials and answers to specific questions.

Once the student has selected several possible internship sites, the next step in the process should be to set up a personal interview at each internship site that holds potential for you. Taking an interview helps the student to gain first hand knowledge about the internship site and provides for the opportunity to meet with staff and other professionals. Hersch and Poey (1984) have developed an interviewing guide to assist the intern in preparing for an on-site interview. Their guide is provided in the next section.

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# A PROPOSED INTERVIEWING GUIDE FOR INTERN APPLICANTS

Jeffrey B. Hersh and Kent Poey*

## A Proposed Interviewing Guide for Intern Applicants

Many internship centers either require or strongly encourage an on-site interview. Some may consider a phone interview. Most will only offer an interview to those applicants who have passed through an initial selection process based on completed written application materials. From our observation the interview is a critical part of selecting intern candidates. Yet many intern applicants appear unprepared to answer rather standard questions. In the interest of clarifying our expectations and hopefully those of other internship centers, we have outlined a series of questions that interns should consider asking intern directors, because such questions typically indicate initiative and interest. There are, however, some questions that are heard in the context of the interview with mixed reactions by intern directors and that may place the intern's evaluation in some negative light. Generally speaking, the best questions are those that reflect motivation to learn and take part in many work activities rather than questions that promote a speculation that the intern may be demanding or complaining.

The listing below is probably more inclusive than encountered in any particular setting. It should be used as a general guide. It is important that the intern applicant prepare himself or herself for the special emphasis of each internship site by anticipating more questions in certain categories than others. For instance, a long discussion of inpatient treatment is unlikely to develop in a training site that primarily provides outpatient services. Our hope is that these lists will be an aid for intern applicants in their preparation for interviews and will be used in conjunction with the published *Survival Guide for Intern Applicants* (Belar & Orgel, 1980). Obviously, preparing for an interview involves more than rehearsing answers to several anticipated questions. We hope the intern candidate will take the opportunity to reflect on his or her learning needs, clinical strengths, and future directions. This contemplative process is invaluable to growth and meaningful challenge in general and will aid the intern candidate in setting his or her priorities for the next year specifically. The intern candidate is also advised to meet with the director of clinical training and other intern applicants for support and feedback.

## Common Questions Asked By Internship Directors

1. General:
   What interests you in this internship program?

(Continued on p. 63.)

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*From *Professional Psychology: Research and Practice*, 15, (1984), pp. 305. Reprint by permission.

# INTERN SITE PRE-SELECTION DATA SHEET

Name of Agency ______________________ Address ______________________

Type of Agency ______________________ Staff Size ______________________

Client/patient population ______________________________________________

**Type of Direct Services Rendered**

| | | | | |
|---|---|---|---|---|
| Inpatient therapy | Yes | ______ | No | ______ |
| Outpatient therapy | Yes | ______ | No | ______ |
| After Care | Yes | ______ | No | ______ |
| Addiction therapy | Yes | ______ | No | ______ |
| Individual therapy | Yes | ______ | No | ______ |
| Group therapy | Yes | ______ | No | ______ |
| Marital therapy | Yes | ______ | No | ______ |
| Family therapy | Yes | ______ | No | ______ |
| Occupational therapy | Yes | ______ | No | ______ |
| Physical therapy | Yes | ______ | No | ______ |

**Intern Experiences Provided (Direct Service)**

| | | | | |
|---|---|---|---|---|
| Inpatient Therapy | Yes | ______ | No | ______ |
| Outpatient Therapy | Yes | ______ | No | ______ |
| Addiction Therapy | Yes | ______ | No | ______ |
| Individual Therapy | Yes | ______ | No | ______ |
| Group Therapy | Yes | ______ | No | ______ |
| Marital Therapy | Yes | ______ | No | ______ |
| Family Therapy | Yes | ______ | No | ______ |

INTERN SITE PRE-SELECTION DATA SHEET

Name of Agency ______________________ Address ______________________

Type of Agency ______________________ Staff Size ______________________

Client/patient population ______________________________________________

Type of Direct Services Rendered

| | | | | |
|---|---|---|---|---|
| Inpatient therapy | Yes | ______ | No | ______ |
| Outpatient therapy | Yes | ______ | No | ______ |
| After Care | Yes | ______ | No | ______ |
| Addiction therapy | Yes | ______ | No | ______ |
| Individual therapy | Yes | ______ | No | ______ |
| Group therapy | Yes | ______ | No | ______ |
| Marital therapy | Yes | ______ | No | ______ |
| Family therapy | Yes | ______ | No | ______ |
| Occupational therapy | Yes | ______ | No | ______ |
| Physical therapy | Yes | ______ | No | ______ |

Intern Experiences Provided (Direct Service)

| | | | | |
|---|---|---|---|---|
| Inpatient Therapy | Yes | ______ | No | ______ |
| Outpatient Therapy | Yes | ______ | No | ______ |
| Addiction Therapy | Yes | ______ | No | ______ |
| Individual Therapy | Yes | ______ | No | ______ |
| Group Therapy | Yes | ______ | No | ______ |
| Marital Therapy | Yes | ______ | No | ______ |
| Family Therapy | Yes | ______ | No | ______ |

Form 3.1, p.1 of 2, Copy 1 & 2

## Administrative Experience

| | | |
|---|---|---|
| Intake Interviewing | Yes ______ | No ______ |
| Testing | Yes ______ | No ______ |
| Scoring | Yes ______ | No ______ |
| Interpreting | Yes ______ | No ______ |
| Report Writing | Yes ______ | No ______ |
| Record Keeping | Yes ______ | No ______ |
| Treatment Planning | Yes ______ | No ______ |
| Consultation | Yes ______ | No ______ |
| Referral | Yes ______ | No ______ |
| Case Summaries | Yes ______ | No ______ |
| Staff Meetings | Yes ______ | No ______ |

## Supervision Provided

| | | |
|---|---|---|
| Direct supervision | Yes ______ | No ______ |
| Individual | Yes ______ | No ______ |
| Group | Yes ______ | No ______ |

## Education Provided

| | | |
|---|---|---|
| Professional training seminars | Yes ______ | No ______ |
| Inservice training | Yes ______ | No ______ |
| Research | Yes ______ | No ______ |

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Administrative Experience

Intake Interviewing Yes ______ No ______
Testing Yes ______ No ______
Scoring Yes ______ No ______
Interpreting Yes ______ No ______
Report Writing Yes ______ No ______
Record Keeping Yes ______ No ______
Treatment Planning Yes ______ No ______
Consultation Yes ______ No ______
Referral Yes ______ No ______
Case Summaries Yes ______ No ______
Staff Meetings Yes ______ No ______

Supervision Provided

Direct supervision Yes ______ No ______
Individual Yes ______ No ______
Group Yes ______ No ______

Education Provided

Professional training seminars Yes ______ No ______
Inservice training Yes ______ No ______
Research Yes ______ No ______

# INTERN SITE PRE-SELECTION DATA SHEET

Name of Agency ____________________ Address ____________________

Type of Agency ____________________ Staff Size ____________________

Client/patient population ________________________________________

**Type of Direct Services Rendered**

| | | |
|---|---|---|
| Inpatient therapy | Yes ______ | No ______ |
| Outpatient therapy | Yes ______ | No ______ |
| After Care | Yes ______ | No ______ |
| Addiction therapy | Yes ______ | No ______ |
| Individual therapy | Yes ______ | No ______ |
| Group therapy | Yes ______ | No ______ |
| Marital therapy | Yes ______ | No ______ |
| Family therapy | Yes ______ | No ______ |
| Occupational therapy | Yes ______ | No ______ |
| Physical therapy | Yes ______ | No ______ |

**Intern Experiences Provided (Direct Service)**

| | | |
|---|---|---|
| Inpatient Therapy | Yes ______ | No ______ |
| Outpatient Therapy | Yes ______ | No ______ |
| Addiction Therapy | Yes ______ | No ______ |
| Individual Therapy | Yes ______ | No ______ |
| Group Therapy | Yes ______ | No ______ |
| Marital Therapy | Yes ______ | No ______ |
| Family Therapy | Yes ______ | No ______ |

INTERN SITE PRE-SELECTION DATA SHEET

Name of Agency ____________________ Address ____________________

Type of Agency ____________________ Staff Size ____________________

Client/patient population ________________________________________

Type of Direct Services Rendered

| | | |
|---|---|---|
| Inpatient therapy | Yes ______ | No ______ |
| Outpatient therapy | Yes ______ | No ______ |
| After Care | Yes ______ | No ______ |
| Addiction therapy | Yes ______ | No ______ |
| Individual therapy | Yes ______ | No ______ |
| Group therapy | Yes ______ | No ______ |
| Marital therapy | Yes ______ | No ______ |
| Family therapy | Yes ______ | No ______ |
| Occupational therapy | Yes ______ | No ______ |
| Physical therapy | Yes ______ | No ______ |

Intern Experiences Provided (Direct Service)

| | | |
|---|---|---|
| Inpatient Therapy | Yes ______ | No ______ |
| Outpatient Therapy | Yes ______ | No ______ |
| Addiction Therapy | Yes ______ | No ______ |
| Individual Therapy | Yes ______ | No ______ |
| Group Therapy | Yes ______ | No ______ |
| Marital Therapy | Yes ______ | No ______ |
| Family Therapy | Yes ______ | No ______ |

## Administrative Experience

| | | |
|---|---|---|
| Intake Interviewing | Yes ______ | No ______ |
| Testing | Yes ______ | No ______ |
| Scoring | Yes ______ | No ______ |
| Interpreting | Yes ______ | No ______ |
| Report Writing | Yes ______ | No ______ |
| Record Keeping | Yes ______ | No ______ |
| Treatment Planning | Yes ______ | No ______ |
| Consultation | Yes ______ | No ______ |
| Referral | Yes ______ | No ______ |
| Case Summaries | Yes ______ | No ______ |
| Staff Meetings | Yes ______ | No ______ |

## Supervision Provided

| | | |
|---|---|---|
| Direct supervision | Yes ______ | No ______ |
| Individual | Yes ______ | No ______ |
| Group | Yes ______ | No ______ |

## Education Provided

| | | |
|---|---|---|
| Professional training seminars | Yes ______ | No ______ |
| Inservice training | Yes ______ | No ______ |
| Research | Yes ______ | No ______ |

Administrative Experience

| | | |
|---|---|---|
| Intake Interviewing | Yes ______ | No ______ |
| Testing | Yes ______ | No ______ |
| Scoring | Yes ______ | No ______ |
| Interpreting | Yes ______ | No ______ |
| Report Writing | Yes ______ | No ______ |
| Record Keeping | Yes ______ | No ______ |
| Treatment Planning | Yes ______ | No ______ |
| Consultation | Yes ______ | No ______ |
| Referral | Yes ______ | No ______ |
| Case Summaries | Yes ______ | No ______ |
| Staff Meetings | Yes ______ | No ______ |

Supervision Provided

| | | |
|---|---|---|
| Direct supervision | Yes ______ | No ______ |
| Individual | Yes ______ | No ______ |
| Group | Yes ______ | No ______ |

Education Provided

| | | |
|---|---|---|
| Professional training seminars | Yes ______ | No ______ |
| Inservice training | Yes ______ | No ______ |
| Research | Yes ______ | No ______ |

Have you worked with client populations similar to to those we see here?

What are some books or articles that you have recently read?

What are some of your specialized skills?

2. Individual Adult Therapy:
What kinds of client problems have you worked with and in what modalities?

What experiences have you had doing emergency work and crisis therapy?

What kinds of cases do you work well with and what kinds of cases present particular problems?

What is your therapeutic orientation? How would you describe your therapeutic style?

Describe your conceptualization and treatment of a recent or current case?

What are your strengths as a therapist and what areas need improvement?

3. Group Therapy:
Have you led groups? What kinds—therapeutic, educational?

Have you had cotherapy experience with groups?

What in the cotherapy relationship was helpful or difficult?

4. Child/Family/Couples Therapy:
What is your experience with child therapy? Family? Couples? Describe the kinds of cases you have worked with, including your theoretical orientation.

What have your co-therapy experiences in family and couples work been like?

5. Inpatient:
Have you had inpatient experiences? Acute care? Long-term care?

Milieu therapy?

What are your strengths in this area and what areas do you need to improve?

6. Psychological Testing:

What is your background in testing?

What tests are you familiar with?

In what specific areas do you want/need further training?

7. Consultation and Education:
What is your background in consultation and education?

Have you collaborated with other professional groups including teachers, lawyers, physicians, and nurses?

Describe your experiences in conducting workshops?

8. Supervision:
What styles of supervision best facilitate your learning?

What styles of supervision tend to inhibit your learning?

What theoretical orientation would you be most comfortable with in supervision?

Describe a rewarding supervision experience?

9. Work With Special Populations:

Have you worked with people with physical complaints?

Have you worked with clients that present handicapped, gay, minority, or cross-culture concerns?

10. Closing:
What areas of your interest are not addressed by this internship?

What areas are especially attractive?

What are your future plans and goals?

### Suggested Questions To Ask Internship Directors

1. How are supervisors assigned? What are their theoretical orientations?
2. How much opportunity is there for me to pursue special learning interests?
3. What kind of activities will I be involved in each week?
4. What is the diversity of the client population?
5. What is the relationship between disciplines and working relationships among the staff and interns?
6. Are there any changes in the stipends, vacations, or medical benefits from what is published in the brochure?

7. What office arrangements are provided for an intern, and what clinical support is available?
8. Is it possible to speak with a current intern?
9. Have past interns found jobs available in this area after the internship?
10. How many people are you interviewing? For how many positions? What is the process by which the selection decision is made? (If there are nonfunded intern positions, ask how decisions are made between funded and nonfunded slots.)
11. What are the strengths and limits of this program?

**Examples of Questions To Avoid Asking Internship Directors**

1. How long does an intern work each week?
2. I want to complete by dissertation during my internship year. Could I have time off to do this?
3. Are there any opportunities to earn extra money in private practice during the internship year?
4. Persistent or antagonistic questions and comments showing a lot of interest in a work area that the internship program only minimally provides.
5. Questions and comments indicating a resistance to learning the major theoretical orientation presented by the internship center.

In conclusion, the interview and selection process is highly charged for intern applicants and internship directors. Both want to be evaluated positively. Unfortunately sometimes the pressure is handled by trying to make arrangements contrary to the Association of Psychology Internship Centers guidelines (APIC, 1982). An intern should discuss any procedural or ethical concerns with his or her university director of training. An area that is clearly unethical is encountered when the possibility of "early" acceptance is raised either by the intern applicant or the internship director. An example of a potentially problematic area is when an intern is asked to rank the internship among his or her potential choices. We hope this question is asked in a flexible and nondemanding way. Our suggestion is for the intern to respond either by saying that more time is needed to sort out his or her priorities or to answer by placing the internship within a range unless it is definitely and unalterably the first choice. Finally, because our remarks reflect our experiences in one internship site, a survey of internship directors regarding their philosophy of interviewing and the questions asked may add substantial support to our remarks or significantly extend them in important ways. We will conduct such a survey that we hope will benefit both intern applicants and internship settings by clarifying priorities and expectations and by opening the interviewing process to inspection.

**References**

Belar, C., & Orgel, S. (1980). Survival guide for intern applicants. *Professional Psychology, 11*, 672-675.

Association of Psychology Internship Centers. (1982). *Directory of internship programs in professional psychology (11th ed.).* Iowa: Author.

■ ■ ■

## THE INTERNSHIP AGREEMENT

Prior to the start of the internship experience, a formal agreement is made between the student's training program (College or University) and the agency or school in which the internship will take place. In most instances, training programs have internship agreements available that serve as the formal contract between the training program and the agency or school. A sample of an internship contract (Sample 4) is included. This may be adapted for use by either counseling or psychology interns.

## UNDERSTANDING THE ORGANIZATION

One of the ultimate ironies that often surrounds the preparation of counselors and other human service professionals is that they spend years of study to try to understand the behavior of clients. Yet upon entering professional practice, they find themselves unable to either understand or to cope with the organizational and interpersonal dynamics that are at work in their own agencies and institutions (Babad & Solomon, 1978).

A contributing factor to the intern initial difficulty is often times the result of not knowing

(Continued on p. 67)

# MEMORANDUM OF AGREEMENT

This agreement is made this ______________ day of ______________ by and between

______________ (hereinafter referred to as the AGENCY/SCHOOL) and ______________

(Hereinafter referred to as the COLLEGE). This agreement will be effective for a period from

______________________ to ______________________ for student

______________________________________________

**Purpose:**

The purpose of this agreement is to provide a qualified graduate student with an internship experience in the field of counseling/therapy.

The COLLEGE shall be responsible for the following:

1. Selecting a student who has successfully completed all the prerequisite courses and the practicum experience.
2. Providing the AGENCY/SCHOOL with a Course Outline for the Supervised Internship in Counseling which clearly delineates the responsibilities of the COLLEGE and the AGENCY.
3. Designating a qualified faculty member as the Internship Supervisor who will work with the AGENCY/SCHOOL in coordinating the internship experience.
4. Notifying the student that he/she must adhere to the administrative policies, rules, standards, schedules, and practices of the AGENCY/SCHOOL.
5. Advising the student that he/she should have adequate liability and accident insurance.

The AGENCY shall be responsible for the following:

1. Providing the intern with an overall orientation to the Agency's specific services necessary for the implementation of the Internship experience.
2. Designating a qualified staff member to function as Supervising Counselor/Therapist for the Intern. The Supervising Counselor/Therapist will be reponsible, with the approval of the Administration of the AGENCY for providing opporunities for the Intern to engage in a variety of counseling activities under supervision, and for evaluating the Intern's performance. (Suggested counseling/therapy experiences are included in the Course Outline.)

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**Sample 4.** An example of an internship contract.

**Equal Opportunity:**

It is mutually agreed that neither party shall discriminate on the basis of race, color, nationality, or ethnic origin, age, sex, or creed.

**Financial Arrangements:**

There are no financial stipulations in this agreement.

**Termination:**

It is understood and agreed by and between the parties hereto that the AGENCY has the right to terminate the Internship experience of the student whose health status is detrimental to the services provided the patients or clients of the AGENCY. Further, it has the right to terminate the use of the AGENCY by an intern if, in the opinion of the Supervising Counselor/Therapist, such person's behavior is detrimental to the operation of the AGENCY and/or to patient or client care. Such action will not be taken until the grievance against any Intern has been discussed with the Intern and with COLLEGE officials.

The names of the responsible individuals at the two institutions charged with the implementation of the contract are as follows:

| | |
|---|---|
| ______________________________ | ______________________________ |
| Internship Supervisor | Agency Supervising Counselor |

In witness Whereof, the parties hereto have caused this memorandum of agreement ot be signed the day and year first written above.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Agency Administrator | Witness |
| ______________________________ | ______________________________ |
| President of College/University | Witness |

**Sample 4.** Continued.

the organizational roles and responsibilities that they are expected to perform. Most students bring to the internship experience a variety of skills and competencies that need to be "fitted" into the existing organizational structure of the agency. This is best accomplished by understanding the roles and relationships in the organization.

### Roles and Responsibilities of the Intern

The beginning intern needs to clarify the role he/she is to play in the organization and to identify the specific tasks to be accomplished in the setting.

Kellog and Burstinger (1979) pointed to a number of critical issues that need to be reviewed by the individual prior to the start of employment. An adaptation of their concepts suggests the following:

1. The intern needs to understand the mission and purpose of the employer's job.
2. The intern needs a list of specific responsibilities that they need to accomplish on the job.
3. The intern needs a description of the working relationships with other positions in the organization.
4. The intern needs to know the specific objective measures on standards of work.
5. The intern needs to understand the assets, contacts, and specialized experience the individual brings to the job and is expected to maintain and develop. These represent the individual's personal investment in the organization.
6. The intern needs a statement of personal liability in the event of individual or organizational failure including the effect on salary, employment, and possible future allocation of human resources.
7. The intern needs a contract that delineates the duties and responsibilities to be required in the internship [Sample 4 is included as an example of a typical contract]. (p. 86)

Having reviewed his/her professional role and knowing the specific tasks that are required, the intern needs to formulate a tentative plan for carrying out the internship. Egan (1987) pointed to the need for the student to develop an *Individual Performance Plan* when entering a system. Egan's categories have been adapted to provide suggestions for the intern.

> **Establish essential linkage.** The intern develops a plan that is linked to the overall mission, strategic plans, and major aims of the organization. The plan is developed in keeping with the university program requirements and the intern's personal training needs.
>
> **List all personal performance areas.** The intern lists all tasks for which he/she is responsible either alone or with others. Specific behaviors should be identified and planned.
>
> **Identify key performance areas.** The intern determines what areas in the agency he/she can become a major contributor. Consideration is given to the students perceived strengths and competencies.
>
> **Set priorities.** The intern develops objectives in each performance area and determines some of the critical accomplishments in that area. Specific objectives that are attainable in a planned time period are specified.
>
> **Develop personal performance indicators.** The intern lists the formative and summative measures that can be used to indicate personal progress and accomplishments (pp. 9-170).

With the completion of the individual performance plan the intern is ready to enter into his/her internship experience armed with information essential to the successful completion of the internship experience.

In summary, the understanding of roles and responsibilities of the intern in the organization enables the intern to avoid any role conflict and prevents other professionals from having different expectations of the intern. A clear understanding of the division of responsibilities and a well developed performance plan enables the intern to work collaboratively and cooperatively with other helping professionals in the agency/institution.

## Supervisory Responsibilities

Solway (1985) described the transition from graduate school to internship as a "passage" that creates considerable stress for the intern. The intern experiences clinical stress in which he/she is apt to feel less confident and secure about skills and competencies. Institutional stress is brought about by the need to understand the inner workings of the institution and lack of familiarity with its structure, procedures, and authority. Personal stress is highlighted by the feelings of separation from the university and adjustment to the new setting.

The field site/internship staff can be aware of and sensitive to the various professional and personal stresses the intern faces and can make themselves available and provide support for the intern. If the intern feels from the start that he/she is in a secure environment and can trust the training staff, he/she will be better able to venture into the agency and will be likely to adjust more easily. As the intern becomes more involved in work, the staff needs to emphasize in words and behavior their continual emotional availability (Koslow & Rice, 1985).

The internship supervisor can facilitate the transition from graduate school to internship by recognizing the need to provide continuous support. As the intern adjusts to the new roles and functions, supervisors can serve as a sounding board from which the intern can begin to formulate an identification with his/her professional role. Providing the intern with a working knowledge of the organizational structure, role relationships and protocols to be followed serve to lessen the intern's initial anxiety.

## Providing Clinical Supervision for the Intern

The ultimate goal of supervision is not simply a more knowledgeable and skilled technician but rather a more human self actualized person. Supervision should provide an extending experience in which the supervisee can blend professional knowledge and personal qualities so as to become even more capable of providing effective help to others in realizing more fully the potentials of their true selves. While part of the supervision is instructional, it goes beyond instruction to focus upon the person or self of the supervisee (Moses & Hardin, 1978).

Delaney (1978) suggested that qualities of effective clinical supervisors should include the following:

- The ability to help supervisees think openly and non-defensively.
- The ability to communicate caring and respect for the supervisee being helped.
- Liking and respecting themselves and not using the supervisee to satisfy their own needs.
- Understanding the supervisee rather than judging the behavior of supervisees he/she is trying to help.
- Identifying behavior patterns that are self-defeating and to help supervisees change these self-defeating behaviors to more personally rewarding behavioral patterns.
- Skill at helping the supervisee look at self and to respond non-defensively to the question Who am I? (p. 353)

Helping the intern "ease" into the process of direct service while at the same time encouraging the intern to test his/her skills and competencies contributes significantly to the personal and professional confidence of the intern.

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# NOTES

## CHAPTER 4

# MONITORING THE INTERACTIONS WITH THE CLIENT

This Chapter is designed to assist the practicum student or intern in assessment and data gathering activities conducted prior to and during counseling/therapy.

The gathering of client data, a requirement of both practicum and internship experiences, can be a difficult task for the beginning counselor/therapist. The amount of client data required, as well as the manner in which data are to be recorded in the client's files, varies from institution to institution and agency to agency. Generally, however, most settings have developed clear guidelines for the obtaining and recording of client data.

The practicum student or intern must first gain a working knowledge of the procedures that are followed and then must develop his/her own framework and style of gathering data. Thus, care must be taken to ensure that the student can process and report data in a clear and concise manner.

## INITIAL CONTACT, ASSESSMENT, AND DATA GATHERING

The initial contact with the client is a crucial point in the process of counseling and therapy. It provides the counselor/therapist with the opportunity to begin structuring the therapeutic relationship.

Structuring the relationship entails defining for the client the nature, purpose, procedures, and goals within the therapeutic relationship. Critical to the structuring process is the therapist's ability to create an atmosphere that enables the client to know that the therapist is genuine, sincere, and empathic in his/her desire to assist the client. Attending skills and facilitative therapeutic techniques are employed by the therapist in the process of preparing the client for data gathering and assessment activities.

Interviewing the client and having the client engage in other assessment procedures are only part of the overall assessment process in counseling and therapy. Equally important is the therapists' own mental or covert activity that goes on during the process. The therapist typically gathers a great amount of information from clients during this stage of counseling/therapy. However, data are of little value or use unless the therapist can integrate and synthesize data.

> The counselor's/therapist's task during the assessment process includes knowing what information to obtain and how to obtain it, putting it together in some meaningful way, and using it to generate clinical hunches, or hypotheses about client's problems, hunches that lead to tentative ideas for treatment planning. (Cormier & Cormier, 1985, p. 147)

★ ★ ★

## ASSESSMENT ACTIVITIES

John C. Boylan

The following is a description and format of typical assessment activities occurring prior to and in the initial stages of counseling/therapy.

### Obtaining Authorizations

The first step in the process of counseling and psychotherapy is obtaining the appropriate authorizations prior to the start of therapy. Examples of authorization forms are included for this purpose: *Parental Release Form* to counsel a child (Form 4.1) and *Client Release Form* to initiate counseling (Form 4.2). These forms should be adapted for use by the practicum student or intern according to the site requirements.

### Obtaining Information From Client and Others

A practical step in obtaining client information from others (teachers, parents, therapists) is to develop a form that focuses upon the specific information to be obtained. For example, *Initial Clinical Intake Forms* (Form 4.3) tend to include more medical/psychological and psychiatric data that focuses upon the history and outcomes of treatment. Similarly, background and developmental data are obtained for the purpose of assessing the acuteness or chronicity of current complaints. In contrast, *School Counseling Referral Forms* (Forms 4.4 and 4.5) tend to include more data regarding the academic history of the student and his/her behavior and demeanor in school. Aptitude, attitude, and interest toward school are typically stressed.

The *Initial Clinical Intake Form* (Form 4.3) is designed to provide the counselor/therapist with initial identifying data about the client. Data about the client are obtained directly from the client at the initial interview.

The *Elementary and Secondary School Counselor Referral Forms* (Forms 4.4 and 4.5) are designed to obtain appropriate pre-counseling data from sources other than the client. Typically, the professional making a referral for counseling/therapy is asked to describe and comment on his/her perceptions and knowledge of the pupil's current academic and social standing.

### Client's Mental Status

To gain insight into the client's presenting condition, the client's mental status may need to be assessed. The mental status examination is, therefore, designed to provide the therapist with signs that indicate the "functional" nature of the person's psychiatric condition. In addition, the mental status examination can be used to provide the therapist with a current view of the client's mental capabilities and deficits prior to and during the course of treatment and is beneficial to the beginning counselor/therapist who lacks the clinical experience to quickly assess the client's mental status.

Many formats can be used to obtain a client's mental status. However, all formats have common areas that are routinely assessed. The following is an example of a fairly typical format and related items for each. *A Mental Status Form* is presented as Form 4.6.

**Appearance and Behavior:** Information gathered by the direct observation of the client. Questions: Is appearance age appropriate? Does the client appear to be their stated age? Is the client's behavior appropriate to the surroundings? Is it overactive/ underactive? Agitated/retarded? Impatient /impulsive?

**Attention/Alertness:** Is the client aware of his/her surroundings? Can the client focus his/her attention on the therapist? Is the client highly distractible? Is the client scanning environment (Hypervigilant)?

**Orientation:** Is the client oriented to person, place, and time? Does the client know with whom he/she is dealing? Where he/she is? What day/time it is?

**Cognition:** Does the client have any memory disturbance? *Recent Memory*—Can the client remember information given a few minutes ago? (Example: Give the client 3 to 4 things to remember and ask him/her to repeat back after several minutes.) *Long Term Memory*—Can the client remember/ recall information yesterday? Childhood? Can the client concentrate on fact given to him/her?

**Judgment:** Can the client act appropriately to typical, social, personal, occupational situations?

**Sensory Perception:** Does the client hallucinate? Does the client experience visual, auditory, tactile, or gustatory false perceptions?

**Thought:** Does the client have false ideas/ delusions? Does the client experience own thoughts as being controlled? Does the client experience people putting thoughts into his/her head? Does the client experience own thoughts being withdrawn/ taken away? Does the client feel that people are watching him/her? Out to get him/her? Does the client experience grandiose or bizarre delusions?

**Emotion:** What is the quality of the client's affect? Is the client's affect expressive/expansive? Is the client's affect blunted (Lack of expression, no emotion, no anger, no joy)? Is the client's affect appropriate to the current situation?

(Continued on p. 101.)

# PARENTAL RELEASE FORM

Parent's Name: ______________________________________________

Address: ______________________________________________

______________________________________________

Phone: ______________________ (Home) ______________________ (Office)

The Graduate Department of Counseling and Psychology at ____________________ College/University conducts a Counseling Practicum Course each semester at the College /University. The Counseling Practicum Course is an advanced course in counseling required of all Degree Candidates in the Counseling Program at ____________________ College/University. Students are required to audio and/or video tape counseling sessions as part of their course and degree requirements.

Student's Name: ______________________________________ would like to work with your son/daughter a student at ______________________________ School.

The counseling sessions conducted with your child will be audio and/or video taped and will be reviewed by the Student's Supervisor (Name): ______________________________. All audio and video tapes made will be erased at the completion of your child's involvement in the program.

We hope that you will take the opportunity to have your child become involved in the Counseling Program. If you are interested in having your child participate, please sign the form where indicated.

Thank you for your cooperation.

Parent's Signature: ______________________________________________

Date: ______________________________

# CLIENT RELEASE FORM

Graduate Department of Counseling and Psychology

________________________________________

(Name of college/university)

I ________________________________________________ agree to be counseled by a practicum/intern student in the Department of Counseling and Psychology at ______________________________ College/University. I further understand that I will participate in counseling interviews that will be audio taped, video taped, and/or viewed by practicum/intern students through the use of one way observation windows. I understand that I will be counseled by a graduate student who has completed advanced course work in counseling/therapy. I understand that the student will be supervised by a faculty member or site supervisor.

Client's Signature ________________________________________

Age ____________________ Date ____________________

Counselor's Signature ________________________________________

Date ____________________

Form 4.2, p.1 of 1, Copy 1

# INITIAL CLINICAL INTAKE FORM

Counselor: ____________ Interview Date: ____________

Client's Name: ____________

Client's Address: ____________

Program: ____________ Admission Date: ____________

## I. Identifying Information

Age: ________ Race: ________ Sex: ________ Religion: ________

Employment: ____________ Marital Status: M S D W SEP

Reason for Admission: ____________ Referral Source: ____________

Current Treatment:

Medical: ________ Type: ________ Provider: ________

Psychiatric/Psychological:

Type: ____________ Provider: ____________

Are you currently taking medications? Yes ______ No ______

If yes, name of medication(s): ____________

Have you received previous psychiatric or psychological treatment? Yes ____ No ____

If yes, Name of Provider: ____________ Location: ____________

Presenting Problem or Condition: ____________

When did the problem begin? ____________

Precipitating factors: (Contributors) ____________

Symptoms:

Acute: ______________________________________________

______________________________________________

Chronic: ______________________________________________

______________________________________________

Family Background (General):

Parents: ____________________ Ages: ________ Living/Deceased: ________

Spouse: ____________________ Age: ________ Living/Deceased: ________

Brothers/Sisters: ____________________ Ages: ________ Living/Deceased: ________

______________________________________________

Children: ____________________ Ages: ________ Living/Deceased: ________

______________________________________________

Treatment Recommendations:

Psychiatric Consult: ________________
Psychological Testing: ________________
Individual Psychotherapy: ________________
Group Psychotherapy: ________________
Family Therapy: ________________
Marital Therapy: ________________
Art Therapy: ________________
Occupational Therapy: ________________
Recreational Therapy: ________________
Psychodrama: ________________
Other (Specify Type): ________________

Recommended Provider: ____________________ Setting: ________________

Date: ________________

Referral: ____________________ Date: ________________

Signature of Therapist: ______________________________________________

# INITIAL CLINICAL INTAKE FORM

Counselor: ____________________ Interview Date: ____________________

Client's Name: ________________________________________

Client's Address: ________________________________________

Program: ____________________ Admission Date: ____________________

## I. Identifying Information

Age: ________ Race: ________ Sex: ________ Religion: ________

Employment: ____________________ Marital Status: M S D W SEP

Reason for Admission: ____________________ Referral Source: ____________________

Current Treatment:

Medical: ____________ Type: ____________ Provider: ____________

Psychiatric/Psychological:

Type: ____________________ Provider: ____________________

Are you currently taking medications? Yes ________ No ________

If yes, name of medication(s): ________________________________________

Have you received previous psychiatric or psychological treatment? Yes ____ No ____

If yes, Name of Provider: ____________________ Location: ____________________

Presenting Problem or Condition: ________________________________________

When did the problem begin? ________________________________________

Precipitating factors: (Contributors) ________________________________________

Form 4.3, p.1 of 2. Copy 2

Symptoms:

Acute: ______________________________

______________________________

Chronic: ______________________________

______________________________

Family Background (General):

Parents: ____________ Ages: ______ Living/Deceased: ______

Spouse: ____________ Age: ______ Living/Deceased: ______

Brothers/Sisters: ____________ Ages: ______ Living/Deceased: ______

______________________________

Children: ____________ Ages: ______ Living/Deceased: ______

______________________________

Treatment Recommendations:

Psychiatric Consult: ____________
Psychological Testing: ____________
Individual Psychotherapy: ____________
Group Psychotherapy: ____________
Family Therapy: ____________
Marital Therapy: ____________
Art Therapy: ____________
Occupational Therapy: ____________
Recreational Therapy: ____________
Psychodrama: ____________
Other (Specify Type): ____________

Recommended Provider: ____________ Setting: ____________

Date: ____________

Referral: ____________ Date: ____________

Signature of Therapist: ______________________________

# INITIAL CLINICAL INTAKE FORM

Counselor: ____________________ Interview Date: ____________________

Client's Name: ________________________________________

Client's Address: ________________________________________

Program: ____________________ Admission Date: ____________________

### I. Identifying Information

Age: __________ Race: __________ Sex: __________ Religion: __________

Employment: ____________________ Marital Status: M S D W SEP

Reason for Admission: ____________________ Referral Source: ____________________

____________________ ____________________

Current Treatment:

Medical: __________ Type: __________ Provider: __________

Psychiatric/Psychological:

Type: ____________________ Provider: ____________________

Are you currently taking medications? Yes __________ No __________

If yes, name of medication(s): ________________________________________

Have you received previous psychiatric or psychological treatment? Yes ______ No ______

If yes, Name of Provider: ____________________ Location: ____________________

____________________ ____________________

Presenting Problem or Condition: ________________________________________

________________________________________

When did the problem begin? ________________________________________

Precipitating factors: (Contributors) ________________________________________

Symptoms:

Acute: ______________________________________________

______________________________________________

Chronic: ______________________________________________

______________________________________________

Family Background (General):

Parents: ____________________ Ages: ________ Living/Deceased: ________

Spouse: ____________________ Age: ________ Living/Deceased: ________

Brothers/Sisters: ________________ Ages: ________ Living/Deceased: ________

______________________________________________

Children: ____________________ Ages: ________ Living/Deceased: ________

______________________________________________

Treatment Recommendations:

Psychiatric Consult: ____________
Psychological Testing: ____________
Individual Psychotherapy: ____________
Group Psychotherapy: ____________
Family Therapy: ____________
Marital Therapy: ____________
Art Therapy: ____________
Occupational Therapy: ____________
Recreational Therapy: ____________
Psychodrama: ____________
Other (Specify Type): ____________

Recommended Provider: ________________ Setting: ____________

Date: ____________

Referral: ________________ Date: ____________

Signature of Therapist: ______________________________

# INITIAL CLINICAL INTAKE FORM

Counselor: ______________________ Interview Date: ______________________

Client's Name: ______________________________________________

Client's Address: ______________________________________________

Program: ______________________ Admission Date: ______________________

## I. Identifying Information

Age: __________ Race: __________ Sex: __________ Religion: __________

Employment: ______________________________ Marital Status: M S D W SEP

Reason for Admission: ______________________ Referral Source: ______________________

______________________________ ______________________

Current Treatment:

Medical: ______________ Type: ______________ Provider: ______________

Psychiatric/Psychological:

Type: ______________________ Provider: ______________________

Are you currently taking medications? Yes ________ No ________

If yes, name of medication(s): ______________________________________

Have you received previous psychiatric or psychological treatment? Yes ____ No ____

If yes, Name of Provider: ______________________ Location: ______________________

______________________________ ______________________

Presenting Problem or Condition: ______________________________________

______________________________________________

When did the problem begin? ______________________________________

Precipitating factors: (Contributors) ______________________________________

Symptoms:

Acute: ______________________________

______________________________

Chronic: ______________________________

______________________________

Family Background (General):

Parents: ____________ Ages: ______ Living/Deceased: ______

Spouse: ____________ Age: ______ Living/Deceased: ______

Brothers/Sisters: ____________ Ages: ______ Living/Deceased: ______

______________________________

Children: ____________ Ages: ______ Living/Deceased: ______

______________________________

Treatment Recommendations:

Psychiatric Consult: ______
Psychological Testing: ______
Individual Psychotherapy: ______
Group Psychotherapy: ______
Family Therapy: ______
Marital Therapy: ______
Art Therapy: ______
Occupational Therapy: ______
Recreational Therapy: ______
Psychodrama: ______
Other (Specify Type): ______

Recommended Provider: ____________ Setting: ______

Date: ______

Referral: ____________ Date: ______

Signature of Therapist: ______________________________

# INITIAL CLINICAL INTAKE FORM

Counselor: ______________________ Interview Date: ______________________

Client's Name: ______________________________________________

Client's Address: ____________________________________________

Program: ______________________ Admission Date: ______________________

## I. Identifying Information

Age: __________ Race: __________ Sex: __________ Religion: __________

Employment: ______________________ Marital Status: M S D W SEP

Reason for Admission: ______________________ Referral Source: ______________

______________________________________ ______________________

Current Treatment:

Medical: ______________ Type: ______________ Provider: ______________

Psychiatric/Psychological:

Type: ______________________ Provider: ______________________

Are you currently taking medications? Yes ________ No ________

If yes, name of medication(s): ______________________________________

Have you received previous psychiatric or psychological treatment? Yes _____ No _____

If yes, Name of Provider: ______________________ Location: ______________________

______________________________________ ______________________

Presenting Problem or Condition: ______________________________________

______________________________________________________________

When did the problem begin? ______________________________________

Precipitating factors: (Contributors) ______________________________________

Symptoms:

Acute:

Chronic:

Family Background (General):

Parents: Ages: Living/Deceased:

Spouse: Age: Living/Deceased:

Brothers/Sisters: Ages: Living/Deceased:

Children: Ages: Living/Deceased:

Treatment Recommendations:

Psychiatric Consult:
Psychological Testing:
Individual Psychotherapy:
Group Psychotherapy:
Family Therapy:
Marital Therapy:
Art Therapy:
Occupational Therapy:
Recreational Therapy:
Psychodrama:
Other (Specify Type):

Recommended Provider: Setting:

Date:

Referral: Date:

Signature of Therapist:

# ELEMENTARY SCHOOL*
# COUNSELING REFERRAL FORM

(Confidential information to be supplied
by teacher or counselor)

Date Referral Received: ______________________

Teacher's Name: ______________________ Date: ______________________
(Form completed by teacher)

Principal's Name: ______________________ School: ______________________

Child's Name: ____________________________________________

Grade: ____________ Date of Birth: ____________ Age: ____________

## TEST RESULTS

I.Q.: ____________ Present Grade Level: ____________

Group: __________ Individual: __________ Math: __________ Reading: __________

If the child has ever been retained--indicate grade: ______________________

Father's Name: ______________________ Mother's Name: ______________________

Address: ______________________ Address: ______________________

Phone Number: ______________________ Phone Number: ______________________

---

*Form developed by Dale Malecki, Elementary Counselor, Abington Heights School District, Clarks Summit, PA. Used with permission.

Have you had discussion with the child's parent(s) regarding this referral? Yes______ No______

Was the parent receptive to you referring the child for counseling?

Positive ____________ Neutral ____________ Negative ____________

To your knowledge, has the child received counseling services in school or out of school?

Yes _____ No _____ If yes, please supply name.

Counselor's or Agency Name: ________________________________

Does the child presently qualify or receive any special education services? Yes______ No______

(If so, give dates): ________________________________

Have the child's parents requested counseling? Yes__________ No__________

Have you discussed your concerns about the child with the building principal? Yes ____ No____

Have you discussed your concerns about the child with the Multi Disciplinary Team (Child Study Team)? Yes__________ No__________

## Student's Present Functioning
(as you perceive it)

| | Excel. | Above Aver. | Aver. | Below Aver. | Poor |
|---|---|---|---|---|---|
| Reading | | | | | |
| Mathematics | | | | | |
| Language Arts | | | | | |
| Social Studies | | | | | |
| General Learning Rate | | | | | |
| On-task-behavior | | | | | |
| Self-directed learner | | | | | |
| Follows directions (oral) | | | | | |
| Follows directions (written) | | | | | |
| Attention Span | | | | | |
| Completes Assignments | | | | | |
| Returns Homework | | | | | |
| Works well with others | | | | | |
| Obeys classroom rules | | | | | |
| Motor coordination | | | | | |
| Self-image development | | | | | |
| Adult relationships | | | | | |
| Peer relationships | | | | | |
| Attitude toward school | | | | | |
| Shows enthusiasm for learning | | | | | |
| Participates in class | | | | | |

## Possible Evidence of
(Check if appropriate)

Daydreams ________________
Easily Distracted ________________
Absenteeism ________________
Withdrawn ________________
Family Problems ________________
Preoccupied ________________
Worries ________________
Lacks Assertiveness ________________
Impulsive Behavior ________________
Poorly Motivated ________________
Inappropriate Academic
Placement ________________

## Other Variables
(Check if applicable)

Vision ________________
Hearing ________________
Speech ________________
Stature ________________
Hygiene ________________
Other (Please specify) ________________

Special Skills, Talents or Competencies child has: ____________________

Reason for Referral (Based on your observations): ____________________

What strategies or techniques have you tried with this child? ____________________

Comments and Recommendations: ____________________

Please indicate a time(s) which will be convenient for you to have a conference with me.

| | | |
|---|---|---|
| Monday | Period | Time |
| Tuesday | Period | Time |
| Wednesday | Period | Time |
| Thursday | Period | Time |
| Friday | Period | Time |

Thank you for taking your time to share this information with me.

Date: ____________________

Signature: ____________________
(Elementary Counselor)

# ELEMENTARY SCHOOL*
# COUNSELING REFERRAL FORM

(Confidential information to be supplied
by teacher or counselor)

Date Referral Received: ______________________

Teacher's Name: ______________________ Date: ______________________
(Form completed by teacher)

Principal's Name: ______________________ School: ______________________

Child's Name: ____________________________________________

Grade: ____________ Date of Birth: ____________ Age: ____________

## TEST RESULTS

I.Q. ____________ Present Grade Level: ____________

Group: ________ Individual: ________ Math: ________ Reading: ________

If the child has ever been retained--indicate grade: ______________________

Father's Name: ______________________ Mother's Name: ______________________

Address: ______________________ Address: ______________________

Phone Number: ______________________ Phone Number: ______________________

---

*Form developed by Dale Malecki, Elementary Counselor, Abington Heights School District, Clarks Summit, PA. Used with permission.

Have you had discussion with the child's parent(s) regarding this referral? Yes______ No______

Was the parent receptive to you referring the child for counseling?

Positive ____________ Neutral ____________ Negative ____________

To your knowledge, has the child received counseling services in school or out of school?

Yes ______ No ______ If yes, please supply name.

Counselor's or Agency Name: ____________________________________

Does the child presently qualify or receive any special education services? Yes______ No______

(If so, give dates): ____________________________________

Have the child's parents requested counseling? Yes__________ No__________

Have you discussed your concerns about the child with the building principal? Yes ____ No____

Have you discussed your concerns about the child with the Multi Disciplinary Team (Child Study Team)? Yes__________ No__________

## Student's Present Functioning
(as you perceive it)

| | Excel. | Above Aver. | Aver. | Below Aver. | Poor |
|---|---|---|---|---|---|
| Reading | | | | | |
| Mathematics | | | | | |
| Language Arts | | | | | |
| Social Studies | | | | | |
| General Learning Rate | | | | | |
| On-task-behavior | | | | | |
| Self-directed learner | | | | | |
| Follows directions (oral) | | | | | |
| Follows directions (written) | | | | | |
| Attention Span | | | | | |
| Completes Assignments | | | | | |
| Returns Homework | | | | | |
| Works well with others | | | | | |
| Obeys classroom rules | | | | | |
| Motor coordination | | | | | |
| Self-image development | | | | | |
| Adult relationships | | | | | |
| Peer relationships | | | | | |
| Attitude toward school | | | | | |
| Shows enthusiasm for learning | | | | | |
| Participates in class | | | | | |

## Possible Evidence of
(Check if appropriate)

Daydreams ____________________
Easily Distracted ____________________
Absenteeism ____________________
Withdrawn ____________________
Family Problems ____________________
Preoccupied ____________________
Worries ____________________
Lacks Assertiveness ____________________
Impulsive Behavior ____________________
Poorly Motivated ____________________
Inappropriate Academic Placement ____________________

## Other Variables
(Check if applicable)

Vision ____________________
Hearing ____________________
Speech ____________________
Stature ____________________
Hygiene ____________________
Other (Please specify) ____________________

Special Skills, Talents or Competencies child has: ____________________

Reason for Referral (Based on your observations): ____________________

What strategies or techniques have you tried with this child? ____________________

Comments and Recommendations: ____________________

Please indicate a time(s) which will be convenient for you to have a conference with me.

| | | |
|---|---|---|
| Monday | Period | Time |
| Tuesday | Period | Time |
| Wednesday | Period | Time |
| Thursday | Period | Time |
| Friday | Period | Time |

Thank you for taking your time to share this information with me.

Date: ____________________

Signature: ____________________
(Elementary Counselor)

## SECONDARY SCHOOL
## COUNSELING REFERRAL FORM

(Confidential Information to be supplied
by teacher or counselor)

Date Referral Received: ____________________

Teacher's Name: ____________________ Date: ____________________
(Form completed by teacher)

Principal's Name: ____________________ School: ____________________

Child's Name: ____________________

Grade: ____________________ Date of Birth: ____________________

### TEST RESULTS

I.Q. __________ Group __________ Individual __________

If the child has ever been retained--indicate grade: ____________________

Father's Name: ____________________ Mother's Name: ____________________

Address: ____________________ Address: ____________________

Phone Number: ____________________ Phone Number: ____________________

Have you had discussion with the child's parent(s) regarding this referral? Yes ______ No ______

Was the parent receptive to you referring the child for counseling?

Positive __________ Neutral __________ Negative __________

To your knowledge, has the student received counseling services in school or out of school?

Yes ______ No ______ If yes, please supply name.

Counselor's or Agency Name: ____________________

Does the student presently qualify or receive any special education services? Yes ______ No ______

(If so, specify): ____________________

Has the student had a psychoeducational assessment done? Yes: __________ No: __________

If so, give date: ____________________

Have the student's parents requested counseling? Yes __________ No __________

Have you discussed your concerns about the child with your supervisor/principal? Yes ____ No ____

Form 4.5, p.1 of 2, Copy 1

## Student's Present Functioning
(as you perceive it)

| | Excel. | Above Aver. | Aver. | Below Aver. | Poor |
|---|---|---|---|---|---|
| Self Directed Learner | ________ | ________ | ________ | ________ | ________ |
| Attention Span | ________ | ________ | ________ | ________ | ________ |
| Quality of Writer Assessment | ________ | ________ | ________ | ________ | ________ |
| Quality of Oral Assessment | ________ | ________ | ________ | ________ | ________ |
| Self Image | ________ | ________ | ________ | ________ | ________ |
| Attitude Toward Authority | ________ | ________ | ________ | ________ | ________ |
| Peer Relationships | ________ | ________ | ________ | ________ | ________ |
| Works well with others | ________ | ________ | ________ | ________ | ________ |
| Completes Assignments | ________ | ________ | ________ | ________ | ________ |
| Follows Classroom Rules | ________ | ________ | ________ | ________ | ________ |

## Please Check
(If appropriate)

Aggressive ________
Assertive ________
Non Complaint ________
Disregard for Rights ________
Self Confident ________
Withdrawn ________
Argumentative ________
Personable ________

Shy ________
Depend ________
Depressed ________
Avoidant ________
Friendly ________
Social ________
Engaging ________

Ambitious ________
Impulsive ________
Preoccupied ________
Motivated ________
Distractible ________

Special Skills, Talents, Competencies Student Has: ________________

________________________________

Reason for Referral (Based upon your observations): ________________

________________________________

What Interventions have you tried with this student? ________________

________________________________

Comments and Recommendations: ________________

________________________________

Date: ________________ Signed: ________________

Position: ________________

# SECONDARY SCHOOL COUNSELING REFERRAL FORM

(Confidential Information to be supplied
by teacher or counselor)

Date Referral Received: ____________________

Teacher's Name: ____________________ Date: ____________________
(Form completed by teacher)

Principal's Name: ____________________ School: ____________________

Child's Name: ________________________________________

Grade: ____________________ Date of Birth: ____________________

## TEST RESULTS

I.Q. __________ Group __________ Individual __________

If the child has ever been retained--indicate grade: ____________________

Father's Name: ____________________ Mother's Name: ____________________

Address: ____________________ Address: ____________________

Phone Number: ____________________ Phone Number: ____________________

Have you had discussion with the child's parent(s) regarding this referral? Yes ______ No ______

Was the parent receptive to you referring the child for counseling?

Positive __________ Neutral __________ Negative __________

To your knowledge, has the student received counseling services in school or out of school?

Yes ______ No ______ If yes, please supply name.

Counselor's or Agency Name: ________________________________________

Does the student presently qualify or receive any special education services? Yes ______ No ______

(If so, specify): ________________________________________

Has the student had a psychoeducational assessment done? Yes: __________ No: __________

If so, give date: ________________________________________

Have the student's parents requested counseling? Yes __________ No __________

Have you discussed your concerns about the child with your supervisor/principal? Yes ____ No ____

Form 4.5, p.1 of 2, Copy 2

## Student's Present Functioning
(as you perceive it)

| | Excel. | Above Aver. | Aver. | Below Aver. | Poor |
|---|---|---|---|---|---|
| Self Directed Learner | | | | | |
| Attention Span | | | | | |
| Quality of Writer Assessment | | | | | |
| Quality of Oral Assessment | | | | | |
| Self Image | | | | | |
| Attitude Toward Authority | | | | | |
| Peer Relationships | | | | | |
| Works well with others | | | | | |
| Completes Assignments | | | | | |
| Follows Classroom Rules | | | | | |

## Please Check
(If appropriate)

Aggressive ____
Assertive ____
Non Complaint ____
Disregard for Rights ____
Self Confident ____
Withdrawn ____
Argumentative ____
Personable ____

Shy ____
Depend ____
Depressed ____
Avoidant ____
Friendly ____
Social ____
Engaging ____

Ambitious ____
Impulsive ____
Preoccupied ____
Motivated ____
Distractible ____

Special Skills, Talents, Competencies Student Has: ____

Reason for Referral (Based upon your observations): ____

What Interventions have you tried with this student? ____

Comments and Recommendations: ____

Date: ____ Signed: ____

Position: ____

# MENTAL STATUS

Client's Name: ____________ Agency: ____________

Client's Age: ____________ Therapist: ____________

Date: ____________

| | Therapist Observations | Therapist Comments |
|---|---|---|
| Appearance and Behavior | | |
| Attention-Alertness | | |
| Orientation | | |
| Cognition | | |

Form 4.6, p.1 of 2, Copy 1

| | **Therapist Observations** | **Therapist Comments** |
|---|---|---|
| Judgment | | |
| | | |
| | | |
| | | |
| Sensory Perception | | |
| | | |
| | | |
| | | |
| Thought | | |
| | | |
| | | |
| | | |
| Emotion | | |
| | | |
| | | |
| | | |

Date ______________________ Therapist Signature ______________________

Form 4.6, p.2 of 2, Copy 1

# MENTAL STATUS

Client's Name: ______________________ Agency: ______________________

Client's Age: ______________________ Therapist: ______________________

Date: ______________________

| | Therapist Observations | Therapist Comments |
|---|---|---|
| Appearance and Behavior | | |
| | | |
| | | |
| | | |
| Attention-Alertness | | |
| | | |
| | | |
| | | |
| Orientation | | |
| | | |
| | | |
| | | |
| Cognition | | |
| | | |
| | | |
| | | |

Form 4.6, p.1 of 2, Copy 2

| | **Therapist Observations** | **Therapist Comments** |
|---|---|---|
| Judgment | | |
| Sensory Perception | | |
| Thought | | |
| Emotion | | |

Date ____________________ Therapist Signature ____________________

**Psycho-Social History**

The use of a *Psycho-Social History* (Form 4.7) is a part of the pre-therapy assessment procedures employed by most community mental health agencies. The *Psycho-Social History* provides the therapist with a comprehensive view of the client over time. In most instances, the *Psycho-Social History* provides more data than the Initial Intake and is invaluable in examining the acuteness or chronicity of the client's problem. Specific attention is directed toward the milestones or benchmarks in the client's developmental history that have implications for the treatment strategies to be employed in therapy.

**Reference**

Cormier, W.H., & Cormier, L.S. (1985). Interviewing strategies for helpers. Monterey, CA: Brooks/Cole.

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## MONITORING THE CLIENT'S PROGRESS

### BUILDING A FOLDER FOR EACH CLIENT*

Joseph W. Hollis

The practicum student or intern also will be responsible for contributing information to the client's file folder maintained by the agency or school in which the counseling sessions are held. Procedures to be followed will depend upon the policies of the agency or school. Each student needs to become informed regarding kinds of information desired and the kinds to be omitted, when and how information is to be added to the folder, and the security procedures to be followed.

Because the practicum/internship course objectives, in addition to those held by the agency or school in which the counseling is done, may necessitate a separate folder for the university supervisor, then a separate client folder may be required for each client. This folder would be maintained by the student counselor and it school site supervisor, the university may be reviewed by the agency or supervisor, and the student counselor.

The purpose in practicum/internship of having a *separate folder* for each client, as part of the requirements may include the following:

- to teach the student counselor the procedures for building a folder for each client similar to what will be required on the job,
- to foster organizational skills in the managing of critical client data,
- to assist the student counselor in gathering pertinent data applicable to the treatment of the client,
- to provide a vehicle for reviewing client progress made during the course of treatment,
- to summarize the therapeutic activities which have been performed by the counselor and client,
- to serve as a format for the preparation and dissemination of summative data of all counseling activities that have taken place prior to and during treatment, and
- to provide essential information when writing a termination report regarding the client.

Thus, the development of a client folder, whether for meeting practicum requirements or for continuing information to the agency, is an invaluable asset to the practicum student or intern.

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*The material was taken from chapter entitled "Initiating Practicum," pp. 33-76 in Kenneth Dimick and Frank Krause, *Practicum Manual for Counseling and Psychotherapy*. Muncie, IN: Accelerated Development, Inc., 1980. Reprinted with permission. (Edited to have terminology consistent with this *Practicum and Internship Textbook*.)

# PROCESSING INTERVIEW NOTES*

Joseph W. Hollis

During or following each counseling/therapy session, the student counselor or therapist will make notes of what occurred and comments regarding future plans for therapy.

With the large number of clients seen in therapy and seen over an extended period of time, the interview notes, Form 4.8, are an invaluable asset to the therapist. Interview notes can serve various purposes.

1. The record of the interview can reacquaint the therapist with what previously had transpired in the contacts as well as with his/her initial impressions of the therapeutic process.

2. Notes may serve as valuable aids in helping a different therapist (who may take over therapy) to understand the developmental nature of the previous contacts in addition to knowledge of the kind of treatment or methods employed in therapy.

3. Of great importance is the value that interview notes have as a self learning device. Notes can help us to check ourselves against the tendencies to be restricted, preoccupied, or sterile in our contacts. Notes have a decided utility in promoting a greater psychological understanding of behavior as displayed by a variety of clients. Much of this understanding can be accomplished by attempting to put into words our impressions and our feelings about the client that too often have been implicitly assumed.

4. Interview notes can be utilized in research and evaluation. They can aid in acquiring more ideas regarding the process itself and movement by the individual when certain techniques are used.

5. Notes serve to keep each helping professional in contact with the work and methods of other professional workers in the same setting. The knowledge gained from what others are doing may serve to help one become more flexible and productive in therapy.

6. Notes may serve as a type of protection for professionals because reference to these notes clarify what actually occurred during the course of therapy.

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*The material was taken from chapter entitled "Counseling Techniques and Processes," pp. 77-174 in Kenneth Dimick and Frank Krause, *Practicum Manual for Counseling and Psychotherapy*, Muncie, IN: Accelerated Development Inc., 1980. Reprinted with permission. (Edited to have terminology consistent with this *Practicum and Internship Textbook*.)

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# A FORMAT FOR INDIVIDUAL PSYCHOTHERAPY SESSION NOTES*

Nan R. Presser and Karen S. Pfost

*This article describes a format for individual case notes. The Individual Psychotherapy Session Note (IPSN) form was designed to focus the clinician's attention on certain relevant aspects of the psychotherapy process and to facilitate the formulation of inferences and hypotheses on the basis of clinical data. It also encourages the therapist to examine his or her own behavior in sessions as well as to observe the therapist-client interaction. The form is designed to be used flexibly, in accordance with the practitioner's needs at different points during therapy. The implications of the IPSN form for training and supervision are also discussed.*

The writing of case notes, although a necessary task, is one for which therapists often receive little or no training. Yet case notes can enhance the therapeutic process by enabling the clinician to assess the validity of conceptualization, to monitor progress toward goals, and

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*This article appeared in *Professional Psychology: Research and Practice*, 1985, Vol. 16, No. 1, 11-16. Reprinted with permission.

(Continued on p. 111)

# PSYCHO-SOCIAL HISTORY

**Directions:** The Practicum/Internship students should complete the form prior to the initiation of therapy and after completion of Initial Intake.

## I. IDENTIFYING INFORMATION

Name: ____________________ Age: ____________

Address: ____________________ Date of Birth: ____________

Phone: ____________________ Marital Status: ____________

## II. PRESENTING PROBLEM/COMPLAINT

Nature of chief complaint: ____________________

When did the problem begin (Date of onset): ____________________

How often does it occur? ____________________

How does it affect your daily functioning: ____________________

Are there events, situations, and person that precipitate it? ____________________

Symptoms:

Acute: ____________________
(Describe)

Chronic: ____________________
(Describe)

Previous treatment (If yes, by whom? Outcome and reason for terminating treatment): ____________________

Medical:

Physician's Name: ______

Treatment Dates From ______ to ______

Describe: ______

Psychiatric:

Therapist's Name: ______

Treatment Dates From ______ to ______

Describe: ______

Prescription Drugs: ______

Substance Usage: ______

Description/Frequency/Amount: ______

## III. DEVELOPMENTAL HISTORY

Pregnancy: ______

Delivery: ______

Infancy (Developmental Milestones): ______

Middle Childhood (Developmental Milestones): ______

Adolescence (Developmental Milestones): ______

Young Adulthood, Middle Adulthood, Late Adulthood (Developmental Milestones): ______

## IV. FAMILY HISTORY

Parents (Names, Ages, Occupation): ____________________

____________________

____________________

Parental Description (Personality/Attitude toward client): ____________________

____________________

____________________

Siblings/significant others (Name, age): ____________________

____________________

____________________

Personality/attitude toward the client: ____________________

____________________

____________________

## V. EDUCATIONAL/OCCUPATIONAL HISTORY

Education (Highest grade achieved; school performance/special classes/ special needs):

____________________

____________________

____________________

Occupational (Job status, kinds of jobs, length of employment, vocational interests):

____________________

____________________

____________________

## VI. HEALTH HISTORY

Childhood disease, prior illnesses, surgery, etc.: ____________________

____________________

____________________

____________________

Current Health (Description of Clinic): ______________________________

______________________________________________________________

______________________________________________________________

Family Health (grandparents, children): ______________________________

______________________________________________________________

______________________________________________________________

Current Medications (Prescribed over the counter): ____________________

______________________________________________________________

______________________________________________________________

## VII. MARITAL HISTORY

Current Status--years married, number of children (problems, stressors, enjoyment):

______________________________________________________________

______________________________________________________________

______________________________________________________________

Client's description of the current relationship with spouse: ______________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Client's perception of sexual relationship (attitudes/behavior): ____________

______________________________________________________________

______________________________________________________________

______________________________________________________________

# PSYCHO-SOCIAL HISTORY

**Directions:** The Practicum/Internship students should complete the form prior to the initiation of therapy and after completion of Initial Intake.

## I. IDENTIFYING INFORMATION

Name: ______________________ Age: ______________

Address: ______________________ Date of Birth: ______________

Phone: ______________________ Marital Status: ______________

## II. PRESENTING PROBLEM/COMPLAINT

Nature of chief complaint: ______________________

______________________

When did the problem begin (Date of onset): ______________________

How often does it occur? ______________________

How does it affect your daily functioning: ______________________

______________________

Are there events, situations, and person that precipitate it? ______________________

______________________

Symptoms:

Acute: ______________________
(Describe)

______________________

Chronic: ______________________
(Describe)

______________________

Previous treatment (If yes, by whom? Outcome and reason for terminating treatment): ______

______________________

______________________

Medical:

Physician's Name: ______________________

Treatment Dates From ______________ to ______________

Describe: ______________________

______________________

Psychiatric:

Therapist's Name: ______________________

Treatment Dates From ______________ to ______________

Describe: ______________________

______________________

Prescription Drugs: ______________________

Substance Usage: ______________________

Description/Frequency/Amount: ______________________

______________________

______________________

## III. DEVELOPMENTAL HISTORY

Pregnancy: ______________________

Delivery: ______________________

Infancy (Developmental Milestones): ______________________

______________________

Middle Childhood (Developmental Milestones): ______________________

______________________

Adolescence (Developmental Milestones): ______________________

______________________

Young Adulthood, Middle Adulthood, Late Adulthood (Developmental Milestones): ______________

______________________

______________________

## IV. FAMILY HISTORY

Parents (Names, Ages, Occupation): ______________________________

______________________________

______________________________

Parental Description (Personality/Attitude toward client): ______________________________

______________________________

______________________________

Siblings/significant others (Name, age): ______________________________

______________________________

______________________________

Personality/attitude toward the client: ______________________________

______________________________

______________________________

## V. EDUCATIONAL/OCCUPATIONAL HISTORY

Education (Highest grade achieved; school performance/special classes/ special needs):

______________________________

______________________________

______________________________

Occupational (Job status, kinds of jobs, length of employment, vocational interests):

______________________________

______________________________

______________________________

## VI. HEALTH HISTORY

Childhood disease, prior illnesses, surgery, etc.: ______________________________

______________________________

______________________________

______________________________

Current Health (Description of Clinic):

Family Health (grandparents, children):

Current Medications (Prescribed over the counter):

## VII. MARITAL HISTORY

Current Status--years married, number of children (problems, stressors, enjoyment):

Client's description of the current relationship with spouse:

Client's perception of sexual relationship (attitudes/behavior):

to note patterns within and across sessions. In training institutions, case notes can serve an additional function: They provide the supervisor with another source of data regarding the supervisee, the client, and the client-therapist relationship. They provide a molar view of therapy that is a valuable precedent to a molecular analysis of events within a session. Case notes also indicate to the supervisor which aspects of therapy are both most salient and most recordable to the supervisee; omissions may serve as cues to focus on areas in supervision, either because they are problematic or inadequately conceptualized. Thus thorough case notes can enhance both the supervisory process and the quality of services delivered and can serve as a safeguard for the supervisor as well.

In our experience, trainees' case notes were typically unfocused narratives of events within a session. Such notes often communicated little regarding process and taught the trainee very little. The Individual Psychotherapy Session Note (IPSN) form was developed for use within a training program. It was designed to focus the trainee's attention on important aspects of therapy sessions and to provide relevant information to the supervisor. Although the IPSN format is especially useful for fledgling clinicians, it is also appropriate for use by more experienced professionals. Its primary emphasis is on process, in contradistinction to the problem focus of other case note formats, most notably the Problem Oriented Medical Record (POMR, Weed, 1968).

The development of the IPSN form was based on three principles. First, the form encourages therapists to attend to several specific, relevant aspects of the therapeutic process. Second, the form is, to the extent possible, atheoretical so that it can be adopted for use by therapists adhering to most theoretical positions. This is especially important for supervisors, who often train clinicians with various theoretical orientations. Third, it was important that the format not be excessively complex, cumbersome, or time-consuming to complete, so that after it has been learned it can be used easily after each session.

The initial version of this form was tested over the course of a year by master's-level clinical and counseling psychology trainees, and by doctoral-level psychology interns. They used the form to record several hundred client sessions occurring in a variety of settings. Systematic feedback from these trainees was used to determine the IPSN's usefulness and to make modifications.

### Description of the IPSN Form

Each of the eight sections of the IPSN form is described below. (See Figures 1 and 2 for replications of the form with sample notes.) What follows is a description of each section of the form.

### I. Brief Summary of Session

This section allows for a narrative overview of the session. Although it is perhaps the least noteworthy section, it allows for the kind of case notes with which many practitioners are familiar and with which they may not be ready to dispense. Entries in this section are most likely to be in the form of a sequential account of major events within the session. Its relative brevity necessitates discrimination among the session's events.

### II. Client

This section (and the following two) forces a clear distinction between data base and inference. The first subsection is provided for the recording of observations of the client's verbal and nonverbal behavior. Objectivity is the key to completion of this subsection, because it is important to resist the temptation to make inferences prior to specification of one's data base. The therapist's hypotheses and inferences are listed in the second subsection. The labeling of this subsection (interpretations and hypotheses) stresses both the speculative nature of such inferences as well as the desirability of further testing of hypotheses.

### III. Therapist

This section encourages the clinician to examine his or her own behavior, retaining the distinction between data base and inferences. Such information is frequently not a part of traditional case notes. The use of this category appears likely to increase the therapist's awareness of his or her own behavior and to alter the

# INDIVIDUAL PSYCHOTHERAPY NOTES

**Client:** Jane Doe
**Date:** 1/14/85
**Session:** 6

## I. BRIEF SUMMARY OF SESSION

Recent argument with her parents regarding lack of progress in finding another job led into discusson of pervasive feelings of inadequacy and hopelessness. She feels incapable of attaining the standards which her parents have set for her, but still she refuses to acknowledge any anger toward them. She appears more depressed and reports increased incidence of self-destructive behaviors. Does not appear to be suicidal at this time.

| THERAPIST'S OBSERVATIONS OF: | THERAPIST'S INTERPRETATIONS AND HYPOTHESES: |
|---|---|
| **II. CLIENT:**<br>At the beginning of session, pt. talked slowly and softly with infrequent pauses; slumped in chair; rarely made eye contact.<br>Later, many self-deprecating statements as she discussed parents' expectations. Raised voice when discussing those, but denied anger.<br>Reported drinking and contact with ex-boyfriend.<br>Hinted re suicide, but denied intent. | Appears moderaly depressed; turning anger inward? May be exacerbated by drinking.<br>Seems threatened by suggestion that she might feel angry toward parents. Over-idealization of them is impedement.<br>Presents self as victim and seems stuck in this role; assumes it with ex-boyfriend and parents.<br>Could hints about suicide and drinking be to elicit rescuing by therapist? |
| **III. THERAPIST**<br>Early in session felt tired, looked at watch frequently.<br>Interventions primarily reflective and clarifying. Tone of voice gentle, soothing. | Initially impatient and bored. Am I becoming tired of her helplessness?<br>Approach is relatively client-centered, with only mild confrontations. Is this avoidance of confrontation my issue (helpless behavior annoys me) or is it due to wanting to avoid recapitualization of victimization? |
| **IV. THERAPIST—CLIENT INTERACTION:**<br>When pt. appears helpless or distressed, therapist is still responding supportively rather than confronting.<br>Pt. asked if therapist was disappiointed in her lack of progress and reported surprise at the negative reply: this was discussed vis-a'-vis her father. | Does pt. typically elicit rescuing, or at times the opposite (frustration and alienating others with her helplessness)?<br>Relationship with therapist is beginning to parallel relationship with father, particularly re projection of negative evaluation onto therapist and expectation of criticism. |

**Figure 1.** Sample notes using a replication of the Individual Psychotherapy Session Notes form. (For the sake of clarity, these notes, which are usually handwritten, have been typeset.)

**V. PROBLEMS ADDRESSED**

1. Pt's feelings of unworthiness and despair re attaining the standards which she has injected.
2. Relationship with parents.
3. Expectations of negative evaluations.

**VI. PROGRESS MADE**

Displays more insight into the connection between internalized standards and her depression.

Beginning to express some of the anger that she has heretofore turned inward.

Her expectation that therapist would also judge her negatively was examined. Therapeutic alliance solidified by discussion of her reaction to therapist.

**VII. PLANS**

In supervision, bring up my reaction to her helplessness and consider reacting differently (first explore if this is my issue and, if not, how best to respond to her).

Look for more signs of anger and point these out as they occur.

Explore idealization of parents.

Continue to monitor suicidal ideation.

**VIII. OTHER**

Will soon need to discuss my absence due to vacation.

**Figure 2.** Sample notes using a replication of the Individual Psychotherapy Session Notes form. (This figure represents the reverse side of the actual form. For the sake of clarity, these notes, which are usually handwritten, have been typeset.)

therapist's perspective so that he or she is both subject and object. The underlying assumption, that the behavior of both parties can be observed and interpreted in a similar manner, discourages the clinician from making attributions regarding his or her own behavior differently from attributions regarding the client's behavior (e.g., situational vs. dispositional). Information in this section also provides a basis for an evaluation of the internal consistency of a therapist's behavior, correspondence to a theoretical stance, and the evolution of a therapist's own style. Data regarding the therapist's reaction to the client can also provide diagnostic information; with experience, the therapist learns to recognize his or her typical responses to persons who display various kinds of behavior.

### IV. Therapist-Client Interaction

This section marks a shift in focus from intra- to interpersonal dynamics. The assumption of reciprocal influence that underlies this section encourages an interactional point of view. Because of the process orientation, this section can be extremely valuable in its illumination of dynamics. It is especially helpful in assisting the therapist to conceptualize both parties' behavior patterns and the degree to which these are specific or nonspecific to this relationship. The novice therapist may tend to underutilize this section of the form, a manifestation of the tendency at that stage of focus on persons (especially the client) rather than on the interaction between the client and the therapist. This section also tends to be used more as the therapeutic relationship develops and as behaviors that were formerly noted in the first or second sections as independent come to be viewed in the context of an interaction.

### V. Problems Addressed

Some clinicians, especially those who work in medical settings, are accustomed to the problem orientation exemplified in the POMR. This section differs from the POMR in that it refers specifically to problems that were *addressed* within the session. This is consistent with the form's focus on the analysis of events within a single session, but it links these events with the subsequent section.

### VI. Progress Made

The assumption behind this section is a rather apparent one—that the client's progress is the ultimate criterion by which therapy must be assessed. The focus on progress highlights the need for movement within therapy, and is also consistent with the American Psychological Association's ethical standards (APA, 1977), which mandate that the basis for continuation of a therapeutic relationship must be its beneficial impact on the client.

### VII. Plans

At this point, attention is shifted from a present to a future focus in order to provide continuity from one session to subsequent ones. This section encourages the clinician to plan therapeutic alternatives and conceptualize issues with which the client will most likely need to deal in future sessions. Practical strategies may also be noted here.

### VIII. Other

This is a category for the information that needs to be recorded but that does not logically belong in any of the previous sections (e.g., test data, relevant correspondence). This section could also be termed as an "overflow" section.

### The IPSNs Use in Supervision

The authors found the IPSN format to be useful in helping fledgling therapists learn concepts and skills requisite for effective therapy. It is rarely possible or desirable to describe everything that occurred in a session. The IPSN assists the novice in learning necessary discrimination skills by prompting him or her to consider and examine those events and observations that are important and why.

Another skill the trainee needs to develop is that of regularly forming hypotheses about a client's behavior, the clinician's own behavior, and the interactions between these two people. Simply noting or observing the client will not lead to effective treatment unless the therapist can put these observations into a theoretical perspective that can eventuate in interventions with potential for producing changes in the client. The form assists the student in forming the habit of relating observations to conceptualizations, conceptualizations to treatment plans, and treatment plans to progress.

This form also can help the trainee to develop higher order observational skills. A trainee needs to learn not only to observe the client's verbal and nonverbal behavior but also to observe the therapeutic process while he or she participates in it. Thus one learns to become simultaneously a participant and an observer during a session in order to ensure control of the session, to understand the therapeutic process on an ongoing basis, and to develop the ability to select appropriate interventions rather than to respond unsystematically. In this respect, the therapist learns to function much like a supervisor who does not participate in a session but observes the client, therapist, and their interaction.

It has been our experience that the developmental stage of the trainee is reflected in how the individual completes the IPSN form. Early in training, therapists typically are able to complete only Sections I, V, VI, and VII comfortably and/or in-depth. The novice tends to focus attention primarily on the client, perhaps as a way of understanding the ambiguity and complexity of psychotherapeutic situations. It is not until later that most trainees seem able to observe and interpret their own behavior in therapy sessions. The ability to perceive, comprehend, and use interactional patterns is an even higher order therapeutic skill. For supervisors, the IPSN may therefore provide a means of assessing their trainees' level of skills and monitoring progress in their development as therapists.

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# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 1

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ____________ Therapist's Signature: ____________

Date: ____________ Supervisor's Signature: ____________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ____________ Therapist's Signature: ____________

Date: ____________ Supervisor's Signature: ____________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________

______________________

______________________

Comments by supervisor: ______________________

______________________

______________________

Date: ______________ Therapist's Signature: ______________

Date: ______________ Supervisor's Signature: ______________

Form 4.8, p.2 of 2, Copy 3

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: __________ Sex: __________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________________________

______________________________________________

Comments by supervisor: ______________________________

______________________________________________

______________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ____________________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio __________________________ Video __________________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: __________ Sex: __________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 6

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________________________

______________________________________________

Comments by supervisor: ______________________________

______________________________________________

______________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 7

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

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______________________________

Date: ______________ Therapist's Signature: ______________

Date: ______________ Supervisor's Signature: ______________

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# INTERVIEW NOTES

Therapist Name: ____________________ Agency/School: ____________________

Therapist Phone: ____________________

## CLIENT IDENTIFYING DATA

Client Name: ____________________ Age: __________ Sex: __________

Date of Interview: ____________________ Interview Number: ____________________

Taping: Audio ____________________ Video ____________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ________________________________________

________________________________________________________

________________________________________________________

Comments by supervisor: ________________________________________

________________________________________________________

________________________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________________________

______________________________________________

Comments by supervisor: ______________________________

______________________________________________

______________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

Form 4.8, p.2 of 2, Copy 9

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: __________ Sex: __________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ________________________________________

______________________________________________________________

______________________________________________________________

Comments by supervisor: ________________________________________

______________________________________________________________

______________________________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ____________________________ Age: _________ Sex: _________

Date of Interview: ____________________ Interview Number: ____________________

Taping: Audio _________________________ Video __________________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

Form 4.8, p.2 of 2, Copy 11

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ____________________________ Age: ________ Sex: ________

Date of Interview: ____________________ Interview Number: ____________________

Taping: Audio _________________________ Video _________________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________________________

______________________________________________

Comments by supervisor: ______________________________

______________________________________________

______________________________________________

Date: ______________ Therapist's Signature: ______________

Date: ______________ Supervisor's Signature: ______________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ______________ Therapist's Signature: ______________

Date: ______________ Supervisor's Signature: ______________

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# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 15

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ________________________________________

__________________________________________________________________

__________________________________________________________________

Comments by supervisor: ____________________________________________

__________________________________________________________________

__________________________________________________________________

Date: ______________________ Therapist's Signature: ______________________

Date: ______________________ Supervisor's Signature: ______________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: __________________________ Age: ________ Sex: ________

Date of Interview: ____________________ Interview Number: ____________________

Taping: Audio __________________________ Video __________________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

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______________________________________________

Comments by supervisor: ______________________________

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______________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________________________

______________________________________________

Comments by supervisor: ______________________________

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______________________________________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 18

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ______________________________

______________________________

______________________________

Comments by supervisor: ______________________________

______________________________

______________________________

Date: ______________ Therapist's Signature: ______________

Date: ______________ Supervisor's Signature: ______________

# INTERVIEW NOTES

Therapist Name: ______________________ Agency/School: ______________________

Therapist Phone: ______________________

## CLIENT IDENTIFYING DATA

Client Name: ______________________ Age: ________ Sex: ________

Date of Interview: ______________________ Interview Number: ______________________

Taping: Audio ______________________ Video ______________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 19

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ____________________

____________________

____________________

Comments by supervisor: ____________________

____________________

____________________

Date: ____________________ Therapist's Signature: ____________________

Date: ____________________ Supervisor's Signature: ____________________

# INTERVIEW NOTES

Therapist Name: ____________________ Agency/School: ____________________

Therapist Phone: ____________________

## CLIENT IDENTIFYING DATA

Client Name: ____________________ Age: ________ Sex: ________

Date of Interview: ____________________ Interview Number: ____________________

Taping: Audio ____________________ Video ____________________

Presenting/Current Concern:

Summary of Interview:

Form 4.8, p.1 of 2, Copy 20

Diagnostic Impression:

Treatment Plan/Objectives:

Comments by therapist/counselor: ____________________

____________________

____________________

Comments by supervisor: ____________________

____________________

____________________

Date: ____________ Therapist's Signature: ____________

Date: ____________ Supervisor's Signature: ____________

* * *

## CASE SUMMARY OUTLINE*

Joseph W. Hollis

Case summaries are essential to synthesize information and to provide baseline data for the counseling process. Summaries enable one to analyze whether or not all essential data regarding the planning and treatment of the client have been considered. In addition, summaries cause one to identify potential problems, directions for action with the client, and possible guidelines for determining whether or not satisfactory progress is being made during the series of therapy sessions.

A case summary also may be written prior to the initial interview. As such, the summary serves as a base for integrating what is known, as a baseline for comparison of future information, and as a springboard of what might be done when the individual is seen in therapy.

In addition, a case summary may be written at various times during the interval over which several therapy sessions were held. The summary may be for the counselor's benefit and as benchmarks for comparisons at a later date. Similarly, a summary may be needed to send to a referral person or to someone the client identifies as needing information about his/her status and/or progress. With those clients being seen within legal conditions (court cases, detention homes, penal institutions) periodic case summaries may be required. The length of the case summary is dependent upon its purpose and the amount and type of information available. One to three pages, single spaced, typewritten generally are sufficient. When appropriate, copies of test data can be incorporated or attached to the case summary.

A typical time for writing a case summary is after termination with the client. The summary will be a vehicle for the review of pertinent information if and when it is needed. The summary is placed in the client folder and maintained along with other pertinent information gathered during the course of therapy.

Items to include in the case summary will be determined by such factors as purpose of the summary, who will use it, and professional expertise of users of the information. Even though items to be included in the case summary will vary from report to report, an outline of topics to be considered is beneficial. (See Sample 5.)

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*The material was taken from chapter entitled "Counseling Techniques and Processes" pp. 77-174 in Kenneth Dimick and Frank Krause, *Practicum Manual for Counseling and Psychotherapy*. Muncie, IN: Accelerated Development Inc., 1980. Reprinted with permission.

# CASE SUMMARY

(Topical Outline)

1. IDENTIFYING DATA

   The name, date, address, and telephone number of the client. Includes agency or school coding (client number, client file, social security number). The background (highest level attained).

2. REASON FOR THE REPORT

   Statement as to the purpose of the current report. Examples include: Interim progress reports of therapy, background information gathered prior to the initial session with the client, referral report to another agency or school, and termination report with the client.

3. SOURCE OF INFORMATION

   The source and the manner in which data was obtained in the preparation of this report.

4. STATEMENT OF THE PROBLEM

   A succinct statement of the presenting problem in therapy. May include a statement of reflecting the chronicity and acuteness of symptomology.

5. FAMILY AND HOME BACKGROUND

   Identifying information about parents and siblings (names, ages, occupations, etc.). Client's perception of the home environment and relationships within the family. Critical family incidents may be included.

6. EDUCATIONAL HISTORY

   Description of pertinent information relation to educational background including academic achievement, school instances that were significant for understanding the individual and the client's attitude toward education.

7. PHYSICAL HEALTH HISTORY

   A statement of the client's significant health history, current treatment and medications; familial medical history that may impact upon the client, current treatments.

8. SOCIAL INTERACTIONS

   Client's perception of the quality of his social interactions and interpersonal relationships.

9. PSYCHOLOGICAL DEVELOPMENT

   Statement of critical benchmarks in the client's psychological development, initial and current clinical impressions.

10. TESTING ASSESSMENT

    Inclusion of the name, form, and other identifying information about each test administered to the client and about tests administered previously by others and the results utilized during the therapy sessions. Scores obtained and identification of norms used in reporting percentiles or other test scores. Interpretation of results.

11. OCCUPATIONAL HISTORY

    Chronology of the client's work history when pertinent, jobs held and reason for change. Quality of work satisfaction and interest.

12. HOBBIES, RECREATIONAL ACTIVITIES

    Interests and self expressional uses of time.

13. SEXUAL ADJUSTMENT

    Current status, significant problems or disturbances in functioning, alternate live styles.

14. SUMMARY STATEMENTS

    Summative statement concerning the client's current disposition and status.

15. DIAGNOSIS/PROGNOSIS

    Statement of the client's DSM III diagnosis and clinical prognosis.

16. TREATMENT

    Description of current treatment and/or recommendations for follow-up treatment.

17. RECOMMENDATIONS

    Summative statement of direct treatment recommendations.

---

**Sample 5.** Topical Outline for Case Summary format

* * *

# REPORTING THERAPEUTIC PROGRESS*

Joseph W. Hollis and Patsy A. Donn

The practicum student or intern frequently may receive requests from others to provide diagnostic information, reports of therapeutic progress, and to make recommendations regarding a client.

The format for reporting client data will vary according to the specific requests that are made. Each progress report needs to be prepared in keeping with the request, the client, and the person to whom the report is sent. Qualitative and quantitative differences will be based upon the professional preparation of the person requesting the data and the orientation and training of the individual preparing the report.

Requests for diagnostic information are often times used by the agency or institution for the purpose of assisting in the development of treatment plans, for placement of client's in appropriate programs, and for providing information for the final disposition of a therapy case. Knowledge of the purpose for which the request is made is invaluable in assisting you in the writing of a progress report that specifically addresses the request.

Requests for treatment recommendations is a vital part of most progress reports. In some instances, the total report consists basically of treatment recommendations. The specific purpose of this report may be simply to communicate recommendations to someone else who must make a disposition of the case.

Requests for report of the client's therapeutic progress are often times requested by the referring professional. Other professionals who have made previous referrals of any kind of the client are appreciative of progress reports even if they are not too formally requested. In addition, others who are working concurrently with the client find progress reports invaluable in fulfilling their professional roles. Teachers, administrators, parents, and physicians can find an appropriately prepared progress report from a fellow professional important source of assistance.

*Therapeutic Progress Reports* (Form 4.9), therefore, need to include pertinent data about the method of treatment employed as well as the client's current status. Treatment recommendations are especially helpful to those who must make a final disposition of the case.

---

*This material was taken from chapter entitled "Developing Reports in Response to Requests from Others," pp. 201-8, in Joseph W. Hollis and Patsy A. Donn, *Psychological Report Writing: Theory and Practice*. Muncie, IN: Accelerated Development Inc., 1979. Reprinted with permission. (Edited to have terminology consistent with this *Practicum and Internship Textbook*.)

# NOTES

# THERAPEUTIC PROGRESS REPORT

Date: ____________________

Therapist: ______________________________ Client's Name: ______________________________

Phone Number: ______________________________ Client's Age: ______________________________

Sessions to date with client (______________________________)
Number

Presenting Complaint: ____________________________________________

____________________________________________

**Therapeutic Summary**

Method of Treatment: ____________________________________________

____________________________________________

Duration of Treatment: ____________________________________________

____________________________________________

THERAPEUTIC PROGRESS REPORT

Date: ____________________

Therapist: ______________________________ Client's Name: ______________________________

Phone Number: ______________________________ Client's Age: ______________________________

Sessions to date with client (______________________________)
Number

Presenting Complaint: ____________________________________________

____________________________________________

Therapeutic Summary

Method of Treatment: ____________________________________________

____________________________________________

Duration of Treatment: ____________________________________________

Current Status: ____________________________________________

____________________________________________

____________________________________________

Treatment Recommendations: ____________________________________________

____________________________________________

____________________________________________

____________________________________________

Signature of Therapist

____________________________________________

Practicum Supervisor/Intern Supervisor

---

Current Status: ____________________________________________

____________________________________________

____________________________________________

Treatment Recommendations: ____________________________________________

____________________________________________

____________________________________________

____________________________________________

Signature of Therapist

____________________________________________

Practicum Supervisor/Intern Supervisor

# THERAPEUTIC PROGRESS REPORT

Date: ____________

Therapist: ____________ Client's Name: ____________

Phone Number: ____________ Client's Age: ____________

Sessions to date with client (____________)
Number

Presenting Complaint: ____________

**Therapeutic Summary**

Method of Treatment: ____________

Duration of Treatment: ____________

THERAPEUTIC PROGRESS REPORT

Date: ____________

Therapist: ____________ Client's Name: ____________

Phone Number: ____________ Client's Age: ____________

Sessions to date with client (____________)
Number

Presenting Complaint: ____________

Therapeutic Summary

Method of Treatment: ____________

Duration of Treatment: ____________

Current Status: ______________________________________________

______________________________________________________________

______________________________________________________________

Treatment Recommendations: ____________________________________

______________________________________________________________

______________________________________________________________

______________________________
Signature of Therapist

______________________________
Practicum Supervisor/Intern Supervisor

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Current Status: ______________________________________________

______________________________________________________________

______________________________________________________________

Treatment Recommendations: ____________________________________

______________________________________________________________

______________________________________________________________

______________________________
Signature of Therapist

______________________________
Practicum Supervisor/Intern Supervisor

Form 4.9, p.2 of 2, Copy 3 & 4

CHAPTER 5

# MONITORING THE PROFESSIONAL DEVELOPMENT OF PRACTICUM STUDENTS AND INTERNS

Supervision of the counselor or psychologist in training is the primary mode by which field-based professional development is facilitated and monitored. The term monitored has been specifically chosen because it implies a steady but unobtrusive action to guide the student, over time, toward higher levels of role mastery. Supervision is the cornerstone of practicum and internship experiences and provides the opportunity for training, data gathering, and feedback regarding the full range of counselor or psychologist professional role activities. Individual supervision, group supervision, peer supervision, and self-supervision are the several modalities of supervision which have been identified in the literature (Hart & Falvey, 1987; Scott, 1976). Individual and group supervision are the modalities which are specifically required by CACREP and APA accreditation guidelines for both practicum and internship experiences.

In order to effectively utilize the various modalities in an integrated manner, a comprehensive framework for defining counselor/therapist skills is necessary. Categories for assessing professional development of counselors have been outlined in the *Handbook of Counseling Supervision* (Borders & Leddick, 1987). These categories—Counseling Performance Skills, Cognitive Counseling Skills, and Developmental Level—will be used as the framework for professional development in this chapter.

## ROLE AND FUNCTION OF THE SUPERVISOR IN PRACTICUM AND INTERNSHIP

The role of the supervisor in practicum and internship is to oversee "a trainee's work for the purpose of facilitating personal and professional development, improving competencies, and promoting accountability in services and programs" (Boyd, 1978, p. 27). Supervisors are considered to be master practitioners who, because of their special clinical abilities and experience, have been identified by the field site to monitor and oversee the professional activities of trainees. University supervisors share a similar role of promoting applied learning skills but have an indirect or liaison relationship to the field site.

The functions of the supervisor have been variously described. Kadushin (1976) outlined supervisory functions in the field of social work as encompassing administration, education, and support. Counselor education literature identifies supervisory functions as consultation, counseling, training, evaluation, and research (Boyd, 1978; Borders & Leddick, 1987). Eckstein (1972), in the specialization area of professional psychology, viewed the supervisor as functioning as therapist, teacher, and administrator.

The area of supervision that perhaps has the most controversy lies in the contrast between clinical supervision functions and administrative supervision functions. *Clinical supervision functions* emphasize counseling, consultation, and training related to the direct service provided to clients by the trainee. *Administrative supervision functions* emphasize work assignment, work review, evaluation, and institutional accountability in services and programs. For example, when clinical supervision is the emphasis, the trainee's development of clinical skills is the focus of the supervisor-supervisee interaction. Feedback is related to professional standards and clinical literature. In contrast, when administrative supervision is the focus, issues such as keeping certain hours, meeting deadlines, following policy and procedures, and making a judgment about whether work is being accomplished at a minimally acceptable level are emphasized. Feedback is related to institutional standards.

A survey conducted by the North Atlantic Region Association for Counselor Education and Supervision (Hart & Falvey, 1987) showed that trainees received equivalent amounts of clinical and administrative supervision each week and that the same person provided clinical and administrative supervision in the majority of responding agencies. Ideally, recommendations are that the same person should not provide both administrative and clinical supervision. If this is not possible, then separate meetings should be scheduled for clinical supervision. This strategy reduces authority and trust conflicts and ensures that reflection on clinical work will not be avoided by focusing on administrative issues (Falvey, 1987).

A trainee can expect to experience both emphases of supervision and feedback. The relative emphasis in this chapter, however, will be on clinical supervision and the intervention, assessment, and evaluation techniques related to a clinical emphasis. The trainee may wish to reflect on the proportion of clinical to administrative supervision he/she is receiving in practicum or internship.

### References

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## SUPERVISOR-SUPERVISEE RELATIONSHIP

Direct supervision of clinical work is perhaps the most important element in the training of a counselor or psychotherapist. Supervision is more than a didactic experience. It includes intensive interpersonal interaction with all of the potential complications which such relationships can include. Research has documented the importance of the supervisor-supervisee relationship. Several studies have related success in supervision to the quality of the relationship between the supervisor and supervisee (Cohen & DeBetz, 1977; Nash, 1975). A study examining supervisee's positive and negative experiences in supervision (Hutt, Scott, & King, 1983) indicated that effective supervision integrates both task and person-oriented behavior. Relationship qualities of warmth, acceptance, trust, and understanding are defined as fundamental to positive supervision. These facilitative relationship qualities are a necessary, but not totally sufficient, condition for positive supervision. Good supervision must integrate both task and relationship-oriented behavior. In positive supervision experiences, a critical balance exists between relationship and task focus. In negative supervision experiences the total emotional focus is on the relationship with its intensely negative focus.

A study examining conflict and conflict resolution within the supervisory relationship outlined three types of conflict (Moskowitz & Rupert, 1983):

> The first category consisted of conflicts that were primarily due to differences between supervisor and trainee in theoretical orientation or views on appropriate therapeutic approach or techniques....
>
> The second category consisted of conflicts that primarily involved the supervisor's style of supervision. Many of these conflicts involved dissatisfaction with the amounts of direction or support provided by the supervisor....
>
> The third category consisted of conflicts that ...reflected a personality clash or personal issues on the part of the trainee or supervisor....(p. 636)

In the study also was reported that "in most cases, these conflicts were discussed and resolved so that the supervisory relationship became a productive one" (p. 639). Even though trainees would have preferred that the supervisor initiate discussion regarding the conflict, such discussions were reported to be initiated by the trainee.

Scott (1976) emphasized the importance of establishing a colleagial relationship within the supervisor-supervisee interaction. The relationship is characterized by balance and a shared responsibility for understanding the counseling process. Disruption of the balance or the inability to establish colleagiality should be an open area of discussion in order to identify learning problems. A general rule is that disruptions in the supervisor-supervisee relationship which occur within the supervisory work always take precedence.

The literature cited in this section may provide the practicum student or intern with sufficient rationale and motivation to consider the supervisor-supervisee relationship as an important area to address during supervision. Relational concerns and conflicts clearly detract from the amount of learning in supervision.

### References

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## APPROACHES IN SUPERVISION

The practicum student or intern often approaches clinical supervision with mixed feelings. On the positive side, supervision can be regarded as a helpful supportive interaction where the work will focus on validating some practices, improving others, and learning new techniques and insights about the counseling process. On the negative side, supervision can be regarded as an interaction which will expose inadequacies and leave the student with even more feelings of incompetence. Both sets of expectations co-exist as the student approaches supervision. The tendency, particularly in the early stages of supervision, is for the student to work at proving himself/herself as a counselor so that the negative inadequate feelings will diminish. This is a natural and underable tendency. However, giving full reign to this tendency would lead the supervision away from the ambiguous aspects of the counseling which require clarification and could lead to avoidance or defensiveness about aspects of the counseling which need improvement. Generally, the initial phases of supervision are spent on establishing a working alliance between the supervisor and supervisee. This holds true across the several approaches to supervision which might be implemented. To reduce the practicum student's or intern's anxieties about supervision and facilitate establishing a working alliance, a preview of how supervision could be implemented is in order. A review of the various practice in counseling supervision has resulted in the identification and explication of four major approaches to supervision (Boyd, 1978).

### Psychotherapeutic Approaches to Supervision

This approach revolves around increasing awareness, understanding, and use of interpersonal and intrapersonal dynamics. The supervisee can expect that awareness of his/her own dynamics will be a focus. Techniques associated with this approach are *interpersonal process recall* (IPR) and unstructured and intensive therapeutic supervision. The IPR technique requires the supervisee to listen to or view an audio or video tape of a session with a client. The recall supervisor uses inductive questioning to direct the counselor's attention to the interpersonal and intrapersonal dynamics in the interaction. The unstructured technique requires that the counselor bring something to the supervisor for discussion. This may be a tape of a session, a professional problem, a consulting concern. If the concern involves any human interaction, the dynamics of the interaction can receive focus. The role of the supervisor is to focus on the dynamics and respond so that the supervisee can give attention to the dynamics involved (Boyd, 1978, pp. 37-81).

### Behavioral Approaches to Supervision

This approach focuses on the skill behaviors of the counselor. Included in skill behaviors are the feelings, thoughts, and acts of the counselor. The goal of Behavioral Supervision is to develop and refine skill behaviors appropriate to counseling. In order to set supervision goals, skill analysis and assessment must be done. Any one of several models which identify skill dimensions of counseling competency may be used as well as the supervisor's own repertoire of identified counseling competencies. Skill behavior analysis is best implemented when the purpose of the skill and the process sequence of the skill is identified and understood. After supervisory goals are set, strategies to accomplish the goal are constructed and implemented (Boyd, 1978, pp. 89-123).

### Integrative Approaches to Supervision

This approach combines methods and techniques from several supervisory approaches and represents the usual practice of a large number of supervisors. The *Carkhuff Training Model* and the *Psychobehavioral Model* are two integrative approaches identified by Boyd (1978). In the Carkhuff Training Model, the practicum student or intern can expect that the supervisor will model facilitative interpersonal skills as well as action oriented skills. While the supervisor offers psychologically facilitative conditions, the supervisee is directed through a three stage program of learning activities: *discrimination training* to recognize and differentiate between high levels and low levels of facilitative conditions; *communication training to develop and demonstrate competence in responding; and developing courses of action* where intervention strategies are taught and practiced.

In the psychobehavioral model a blend of insight counseling and action oriented counseling is utilized. The practicum student or intern can expect to proceed through three stages of supervision:

1. the initial stage—self-exploration of anxieties and expectations and experiences focusing on interpersonal and intrapersonal dynamics are combined with skill development activities;
2. the intermediate stage—a more confrontative supervision which examines dynamic patterns and provides therapeutic feedback from the supervisor is utilized; and
3. the terminal stage—the supervisor functions more as a consultant and training activities are minimal (Boyd, 1978, pp. 135-68).

### Systems Approach to Counselor Supervision

In this approach systems technology is applied to the supervisory function. The trainee and his/her performance are viewed in the context of the helping services the counselor is responsible for delivering. The supervisor is a consultant who collaborates with trainees in conceptualizing the counseling activities in terms of broad goals and performance objectives within the total counseling or helping service program. The practicum student or intern can expect to meet with the supervisor to review an activity plan to determine how realistic it may be and how likely it is to reach intended goals and objectives (Boyd, 1978, pp. 171-92).

The four approaches to supervision which have been reviewed are those which are most likely to be experienced by the practicum student or intern. Because the trainee will probably have more than one supervisor during his/her field experiences, the probability is that he/she may be working with a university supervisor who utilizes the Behavioral Approach to supervision at the same time he/she may be working with a field site supervisor who utilizes a Systems Approach to supervision. The trainee is advised to be open to any one of the approaches to supervision by recognizing goals and advantages inherent in each of the approaches.

### References

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## ASSESSING PROFESSIONAL DEVELOPMENT

A comprehensive framework for defining skills categories for the counselor-in-training has been proposed in the *Handbook of Counseling Supervision* (Border & Leddick, 1987). Three broad skill categories have been identified as those within which self assessment, supervisor assessment, goal identification, and evaluation can be implemented.

The first skill category is *Counseling Performance Skills.* The counseling performance skills refer to "what the counselor does during a session or his counseling behaviors" (p. 14). This includes (1) the basic helping skills such as attending behaviors, primary and advanced empathy, concreteness, effective self-disclosure; (2) theory-based techniques such as challenging irrational beliefs or relaxation training; and (3) procedural skills such as opening or closing an interview or managing special issues such as suicide.

The second skill category is *Cognitive Counseling Skills.* This refers to "how the counselor thinks about the client and chooses interventions" (p. 16). This is an area of professional development which has received relatively less attention than the performance skill categories. Nevertheless this area is integral to the mastery of the counselor or psychologist professional role. Trainees need to be able to discriminate important client data from less important client data. They must be able to sort through and synthesize information in order to identify underlying patterns and themes which helps in the understanding of client problems. And finally, they must be able to formulate clinical hypotheses in order to be planful about interventions and recommendations. This skill category will most likely be emphasized at the more advanced levels of field experience. However awareness of important information and the ability to discriminate between important and unimportant information is part of early training.

A third skill category is the *developmental level.* This refers to the degree to which trainees are able to internalize the role of counselor and achieve a peer-like colleagial relationship with the supervisor. Assessment and evaluation in this category can help identify the personal and professional issues the trainee is facing. For example, the trainee might be described as functioning at a dependent and primarily imitative level. The trainee might be described as lacking awareness of his/her own personal needs and motivations. At higher developmental levels the trainee might be described as able to understand his/her own strengths and weaknesses. This is often a difficult area in which to self assess and will require some dialogue with the supervisor in order to be specific in identifying personal and professional concerns.

We suggest that the practicum student or intern spend time early in the supervisory relationship discussing and clarifying these skill categories. This discussion will facilitate the self assessment process for the trainee. At the early phases of practicum, the possibility may be that the counselor performance skills area will be targeted for work while the areas of cognitive in the counseling skills and developmental level may be more background and have primarily awareness level goals. At the advanced phases of internship, the possibility may be that the counselor performance skills area is background and cognitive counseling skills and developmental level areas are targeted for work. (See Figure 5.1.) The framework suggested here can be adapted to the individual needs of the trainee at various stages of experiences.

### Reference

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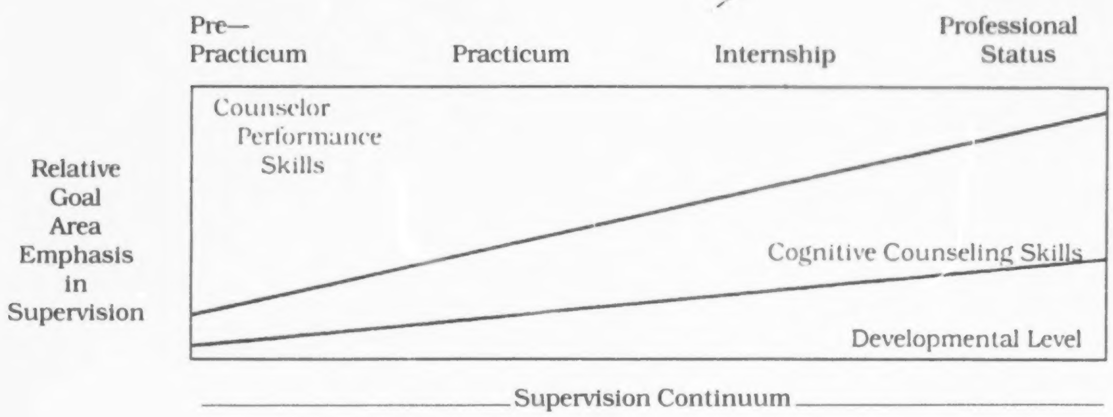
Pre—
Practicum
Practicum
Internship
Professional
Status
Relative Goal Area Emphasis in Supervision
Counselor Performance Skills
Cognitive Counseling Skills
Developmental Level
Supervision Continuum

**Figure 5.1.** Schematic representation of relative goal emphasis in supervision and the shift in goal emphasis as the student progresses from pre-practicum to completion of internship.

* * *

## SELF ASSESSMENT TO SET GOALS FOR SUPERVISION

Judith Scott

Several kinds of self-assessment are utilized throughout the practicum and internship experience. The first type of self assessment occurs at the beginning of establishing a supervisory contract. We recommend that the trainee begin the supervisory process by reviewing, in a systemmatic way, the educational preparation, related work experiences, volunteer activities, peer interactions, and previous supervision related to counseling which he/she brings to the current field training situation. Trainees who are just beginning a practicum experience often have rich histories of involvement in paraprofessional counseling activities and training which will allow them to draw on previous interaction as a helper. These may be as varied as student resident hall assistant, volunteer worker at a residential treatment facility, peer counselor, volunteer at a how line or crisis center. The self assessment should begin with a review of applied helping activities and related training experiences. Form 5.1 is a sample *Self Assessment form.* This is intended for use as a stimulus to a dialogues regarding goals between the supervisor and supervisee. Additional items can be added according to supervisor-supervisee preference. Standardized assessment instruments are recommended for objective evaluation. Self assessment in the area of Developmental Level is not included in the form. However, previous experiences in the helping role and stated short-term and long-term goals for supervision can provide a basis for a tentative understanding of developmental level.

When negotiating the supervisory contract for the internship, previous records of practicum assessment records and evaluation can be utilized in the new goal setting process. We recommend that the assessment be organized into the categories of counseling performance skill and cognitive counseling skills as included in the sample Self Assessment Form 5.1.

An additional self assessment activity which can be used prior to meeting with a new supervisor and setting goals for supervision is completion of the Counseling Techniques List.

■ ■ ■

# SELF ASSESSMENT FOR PRACTICUM STUDENTS

**Purposes:**

1. To provide the practicum student with an opportunity to review levels of competency in performance skills and cognitive skills.
2. To provide the practicum student with a basis for identifying areas of emphasis within supervision.

**Directions:**

1. Student completes the form in duplicate and gives copy to supervisor.
2. In first section, complete a history of experiences in the helping relationship. List related training for supervision.
3. In second section, circle a number to indicate performance: continuum is from 1, which is poor, to 5, which is good.

## SECTION ONE: Resume' of past experiences in the Helping Relationship

| Date | Role & Setting | Related Training and/or Supervision |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## SECTION TWO: Skills Assessment

POOR AVERAGE GOOD

1. Knowledge of facilitative skills (warmth, primary empathy, genuineness, concreteness) 1 2 3 4 5
2. Ability to apply facilitative skills 1 2 3 4 5
3. Knowledge of challenging skills (self disclosure, advanced empathy, confrontation) 1 2 3 4 5
4. Ability to apply challenging skills 1 2 3 4 5
5. Ability to facilitate client self exploration 1 2 3 4 5
6. Ability to recognize and handle positive affect 1 2 3 4 5
7. Ability to recognize and handle negative affect 1 2 3 4 5
8. Ability to begin and end session 1 2 3 4 5

POOR AVERAGE GOOD

9. Ability to establish continuity from session to session 1 2 3 4 5
10. Awareness of meaningful client data 1 2 3 4 5
11. Ability to discriminate between meaningful and irrelevant client data 1 2 3 4 5
12. Ability to organize case material 1 2 3 4 5
13. Ability to recognize implications of case material 1 2 3 4 5
14. Ability to analyze counselor/client interaction 1 2 3 4 5
15. Ability to formulate a clinical hypothesis 1 2 3 4 5
16. Ability to test and revise a clinical hypothesis 1 2 3 4 5

BEST COPY AVAILABLE

| | POOR | | AVERAGE | | GOOD |
|---|---|---|---|---|---|
| 17. Ability to facilitate goal development with client | 1 | 2 | 3 | 4 | 5 |
| 18. Knowledge of counseling theory-based techniques (Please List) | | | | | |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| 19. Ability to apply theory-based techniques (Please List) | | | | | |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |

Write a brief statement concerning your needs in supervision.

Tentative Goal Statement for Supervision

Short-term Goal:

Long-term Goal:

Date: ____________________

Practicum Student Signature: ____________________

Supervisor Signature: ____________________

# SELF ASSESSMENT FOR PRACTICUM STUDENTS

**Purposes:**

1. To provide the practicum student with an opportunity to review levels of competency in performance skills and cognitive skills.
2. To provide the practicum student with a basis for identifying areas of emphasis within supervision.

**Directions:**

1. Student completes the form in duplicate and gives copy to supervisor.
2. In first section, complete a history of experiences in the helping relationship. List related training for supervision.
3. In second section, circle a number to indicate performance: continuum is from 1, which is poor, to 5, which is good.

## SECTION ONE: Resume' of past experiences in the Helping Relationship

| Date | Role & Setting | Related Training and/or Supervision |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## SECTION TWO: Skills Assessment

| | POOR | | AVERAGE | | GOOD |
|---|---|---|---|---|---|
| 1. Knowledge of facilitative skills (warmth, primary empathy, genuineness, concreteness) | 1 | 2 | 3 | 4 | 5 |
| 2. Ability to apply facilitative skills | 1 | 2 | 3 | 4 | 5 |
| 3. Knowledge of challenging skills (self disclosure, advanced empathy, confrontation) | 1 | 2 | 3 | 4 | 5 |
| 4. Ability to apply challenging skills | 1 | 2 | 3 | 4 | 5 |
| 5. Ability to facilitate client self exploration | 1 | 2 | 3 | 4 | 5 |
| 6. Ability to recognize and handle positive affect | 1 | 2 | 3 | 4 | 5 |
| 7. Ability to recognize and handle negative affect | 1 | 2 | 3 | 4 | 5 |
| 8. Ability to begin and end session | 1 | 2 | 3 | 4 | 5 |
| 9. Ability to establish continuity from session to session | 1 | 2 | 3 | 4 | 5 |
| 10. Awareness of meaningful client data | 1 | 2 | 3 | 4 | 5 |
| 11. Ability to discriminate between meaningful and irrelevant client data | 1 | 2 | 3 | 4 | 5 |
| 12. Ability to organize case material | 1 | 2 | 3 | 4 | 5 |
| 13. Ability to recognize implications of case material | 1 | 2 | 3 | 4 | 5 |
| 14. Ability to analyze counselor/client interaction | 1 | 2 | 3 | 4 | 5 |
| 15. Ability to formulate a clinical hypothesis | 1 | 2 | 3 | 4 | 5 |
| 16. Ability to test and revise a clinical hypothesis | 1 | 2 | 3 | 4 | 5 |

| | POOR | | AVERAGE | | GOOD |
|---|---|---|---|---|---|
| 17. Ability to facilitate goal development with client | 1 | 2 | 3 | 4 | 5 |
| 18. Knowledge of counseling theory-based techniques (Please List) | | | | | |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| 19. Ability to apply theory-based techniques (Please List) | | | | | |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |

Write a brief statement concerning your needs in supervision.

Tentative Goal Statement for Supervision

Short-term Goal:

Long-term Goal:

Date: ____________________

Practicum Student Signature: ____________________

Supervisor Signature: ____________________

# TECHNIQUES USED IN COUNSELING AND PSYCHOTHERAPY*

Joseph W. Hollis

Major growth has occurred in counseling and psychotherapy professions in recent years. Different philosophical positions have given rise to new theories which in turn have produced a search for additional approaches. The number of counselors, therapists, and clinicians has increased, while also expanding the scope of individuals with whom counseling services have been available.

Because no one counseling technique is appropriate for all clients or is flexible enough to use at the various depths required in counseling, additional counseling techniques have become a necessity. Research and experimentation have led to new techniques and to an identification of which techniques are most appropriate when using a specific theoretical base with a client in remedial, preventive, or developmental area. Thus, the counseling profession has developed to the stage where each counselor can select techniques according to his/her own philosophical base and according to the client's needs. When the counselor recognizes his/her own limitations in using a wide range of techniques, this knowledge would enable the counselor to refer certain clients, seek consultation when working with some clients, request co-counselor or co-therapist to work with specific clients, or limit one's practice to clients who can be assisted with the competencies of the counselor.

The following list of counseling and psychotherapy techniques is not all inclusive but does represent techniques used by a broad spectrum of philosophical bases. The number of counseling techniques used by any one counselor varies. By a counselor reviewing his/her tape recordings from several sessions with different clients, ten to fifteen techniques may be identified which were used frequently with competence. An additional ten to fifteen may be identified which were used but used less frequently or in some cases with less professional competency.

Suggestions for using the following techniques list are dependent upon ones professional development. Students in ge of my courses use the list primarily in two ways:

1. to checkout and expand their knowledge about counseling techniques and
2. to introspect into their own counseling, philosophical bases, and treatment approaches.

## DIRECTIONS FOR USE OF THE TECHNIQUES LIST

First, examine the techniques listed in column one. Then technique by technique decide the extent to which you do or would be competent to use each. Indicate the extent of use or competency by circling the appropriate letter in column two. If you do not know the technique, then mark an "X" through the "N" for an indication that the technique is unknown. Space is provided at the end of the techniques in column one to add other techniques.

Second, after completing examination of the list and indicating your extent of use or competency, then go through the techniques list again and mark in the third column the theory or theories with which each technique is appropriate. The third column of course can be marked only for the techniques with which you have knowledge.

The third task is to become more knowledgeable about techniques which you do not know—the ones marked with "X." As you gain knowledge relating to each technique, you can decide whether or not you will use it and, if so, with which kinds of clients and under what conditions.

The fourth task is to review columns two and three and determine whether or not techniques in which you have competencies are within one or two theories. If so, are these theories the ones which best reflect your self concept? Do those techniques marked reflect those most appropriate, as revealed in the literature, for the clients with whom you want to work?

---

*The material was taken from chapter entitled "Counseling Techniques and Processes," pp. 77-174 in K. Dimick and F. Krause (Eds.), *Practicum Manual for Counseling and Psychotherapy*. Muncie, IN: Accelerated Development. Reprinted with permission.

(Read the material on preceding page before proceeding.)

---

**Technique**

Extent of Use or Competency

N = None
M = Minimal
A = Average
E = Extensive

Circle one to represent extent
Mark X across the N if technique is unknown.

Theories With Which Technique Is Most Appropriate

Be = Behavioral Modification (Wolpe)
Cl = Client Center (Rogers)
Co = Conjoint Family (Satir)
Ex = Existential (May)
Ge = Gestalt (Perls)
Lo = Logo (Frankl)
Ps = Psychoanalytic (Freud)
RE = Rational Emotive Therapy (Ellis)
TA = Transactional Analysis (Berne)
TF = Trait Factor (Williamson)
CT = Cognitive Therapy (Beck)
Circle one or more

| | | |
|---|---|---|
| acceptance | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| active imagination | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| active listening | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| advice giving | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| alter-ego | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| analyzing symbols | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| analysis | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| assertive training | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| audiotape recorded models | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| authoritarian approach | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| aversion-aversive conditioning | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| | | |
| behavior modification | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| bibliotherapy | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| break-in, break-out | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| bumping in a circle | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| | | |
| cajoling | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| case history | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| catharsis | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| chemotherapy | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| clarifying feelings | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| cognitive restructuring | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| commitment | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| conditioning techniques | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| confession | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| confrontation | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| congruence | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| contractual agreements | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| co-therapist | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| counter propaganda | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| counter transference | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| crying | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |

| | | |
|---|---|---|
| decision making | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| democratic | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| desensitization | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| detailed inquiry | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| diagnosing | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| doubling | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| dream interpretation | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| dreaming | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| drugs | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| empathy | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| encouragement | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| environmental manipulation | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| explaining | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| fading | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| family chronology | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| family group counseling | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| fatasizing | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| feedback | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| filmed models | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| first memory | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| free association | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| frustration | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| game theory techniques | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| group centered | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| group play | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| homework | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| hot seat | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| identification of an animal, defend it | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| identification of self as great personage | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| imagery | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| inception inquiry | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| informativity | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| interpersonal process recall--IPR | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| interpretation | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| irrational behavior identification | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| laissez faire groups | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| life space | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| live models | N M A E | Be Cl Ex Ge Lo Ps RE TA TF CT |
| magic mirror | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| misinterpretation, deliberately | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| modeling | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| multiple counseling | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |

natural consequences ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
negative practice ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
negative reinforcement ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

orientative ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

paradoxical intention ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
play therapy ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
positive regard ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
positive reinforcement ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
predicting ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
probing ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
problem solving ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
processing ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
prognosing ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
progressive relaxation ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
projection ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
psychodrama ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
punishment ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

questioning ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

rational ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reality testing ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reassurance ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
recall ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reciprocity of affect ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reconscience ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
re-education ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reflection ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
regression ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reinforcement ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
relaxation ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
release therapy ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
restatement of content ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
reward ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
rocking or cradling above head trust ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
role playing ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
role reversal ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

self-modeling ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
sensitivity exercises ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
sensitivity training ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
shaping ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
silence ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
simulation ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
sociodrama ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
sociometrics ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
stimulation ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
structuring ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
SUD (Subjective Unit of Discomfort) ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT
summarization ........ N M A E ........ Be Cl Co Ex Ge Lo Ps RE TA TF CT

| | | |
|---|---|---|
| supporting | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| systematic desensitization | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| termination | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| transference | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| transparency | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| trust walk | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| urging | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| value clarification | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| value development | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| verbal shock | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| vicarious learning | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| warmth | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| ADD YOUR OWN | | |
| ____________ | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| ____________ | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |
| ____________ | N M A E | Be Cl Co Ex Ge Lo Ps RE TA TF CT |

## ON-GOING SELF ASSESSMENT

Continuing reflection upon and assessment of one's counseling practices are an integral part of the practicum and internship experiences. This on-going self assessment occurs while transcribing interview notes, reviewing tapes of counseling sessions, preparing material to take to supervision, and keeping journals of personal feelings and attitudes about counseling practice. A number of different forms and directed activities can assist the trainee with organizing and focusing these self assessment activities. We suggest that the trainee keep a file of all self assessment activities as a record of his/her professional development.

Two forms which have appeared in other sections of this manual are aids for focusing self assessment. The *Tape Critique Form* (Chapter 2, Form 2.4) provides a systematic approach to reviewing and assessing sessions which have been audio or videotaped. The *Interview Notes* (Chapter 4, Form 4.8) and the *Case Summary* (Chapter 4, Sample 5) provide an organization for written review of counseling sessions and can demonstrate cognitive counseling skills and developmental level of the trainee. Two additional aids for self assessment are included here. These are a *Self Rating* (Form 5.2) to be used after a therapy session and a directed self assessment activity to be used in analyzing counseling interviews.

■ ■ ■

(Form 5.2 appears at end of chapter.)

* * *

# ANALYZING COUNSELING INTERVIEWS: THE VERBAL INTERACTIONAL ANALYSIS TECHNIQUE*

Rod Fowler and Paul DeVivo

As counselor educators, we have learned experientially the appropriateness of the advice, "No right way for counseling practicum has been perfected." Concern with addition to our repertoire of supervisory techniques that would offer palatability to both professor and learner led us to explore the literature for more concrete and less threatening supervisory systems.

Because the majority of our supervision is done with counseling sessions recorded on audiotapes, we focused our search on systems concerned with verbal behavior only. While we are aware of the importance of nonverbal communication, we also are cognizant that prominent scholars studying nonverbal communication today agree that to compile concrete, consistently accurate explanations of the meaning of nonverbal behavior is impossible (Walters, 1978). Our search led us to the opinion that verbal communication could be analyzed with higher reliability than could nonverbal communication.

## FLANDERS INTERACTION ANALYSIS SYSTEM (FIAS)

Amidon and Flanders (1967) demonstrated that analysis of verbal interaction between teachers and students was important to teachers for two reasons and Kryspin and Feldhusen (1974) added the third one in the following list:

1. Teachers continuously influence students in the classroom.
2. Teachers can gain insight into the ways they influence students.
3. Teachers can change their behavior to influence students to learn more.

We believe that the analysis of verbal interaction between counselors and clients is important for the same reasons with a modicum of modification:

1. Counselors continuously influence clients in counseling interviews.
2. Counselors can gain insight into the ways they influence clients.
3. Counselors can modify their behavior to influence clients' change in positive ways.

The use of the *Flanders Interaction Analysis System* (FIAS) has shown a positive correlation with pupil independence (Flanders & Amidon, 1962). If pupil independence, attitude, and achievement are related to teacher effectiveness, and if the FIAS is a reliable means of evaluating this effectiveness, would it not hold true that an adaptation of the FIAS could be useful in evaluating the effectiveness in an interview of student counselors in the practicum milieu?

The FIAS originally was developed as an aid in gathering research data (Flanders, 1970). It was then extended to techniques designed to improve teacher effectiveness. When committed to audio- or videotape, the verbal interactions can be analyzed by the teacher (or counselor) at a more convenient time.

## CATEGORIES OF VERBAL BEHAVIOR

In this system, the verbal behavior in the classroom is divided into ten categories as shown in Figure 1. All teacher statements are classified in the first seven categories. Teacher statements are classified as either indirect (categories one through four) or direct (categories five through seven). Indirect teacher influence consists of four observation categories: (1) acceptance of feeling, (2) praise or encouragement, (3) acceptance of ideas, and (4) asking questions.

Direct teacher influence is divided into three categories: (5) explaining or informing, (6) giving directions, and (7) scolding/reprimanding or defending authority.

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*This material was taken from chapter entitled "Evaluation of Student Counselors and Supervisors," pp. 265-314 in Kenneth Dimick and Frank Krause (Eds.), *Practicum Manual in Counseling and Psychotherapy*. Muncie, IN: Accelerated Development, 1980.

| | |
|---|---|
| **INDIRECT TEACHER TALK** | 1. ACCEPTS FEELINGS: accepts and clarifies feelings of the students in a nonthreatening manner. Feelings may be positive or negative. Predicting and recalling feeling are included. |
| | 2. PRAISES OR ENCOURAGES: praises or encourages student action or behavior. Jokes that release tension, not at student's expense, nodding head or saying "uh-huh" or "go on" are included. |
| | 3. ACCEPTS OR USES STUDENT IDEAS: clarifying, building, or developing ideas or suggestions by the student. As teacher brings more of his own ideas into play, shift to category five. |
| | 4. ASKS QUESTIONS: asking a question about content or procedures with the intent that a student answer. |
| **DIRECT TEACHER TALK** | 5. EXPLAINING OR INFORMING: giving facts or opinions about content or procedures; expressing his own idea; asking rhetorical questions. |
| | 6. GIVES DIRECTIONS: directions, commands, or orders with which a student is expected to comply by action. |
| | 7. SCOLDING/REPRIMANDING OR DEFENDING AUTHORITY: talk by students in response to teacher. Teacher initiates the contact or solicits student statement. |
| **STUDENT TALK** | 8. STUDENT TALK--EXPECTED OR PREDICTABLE RESPONSE: talk by students in response to teacher. Teacher initiates the contact or solicits student statement. |
| | 9. STUDENT TALK--INITIATED RESPONSE: talk by students, which they initiate. If "calling on" student is only to indicate who may talk next, observer must decide whether student wanted to talk. If he did, use this category. |
| **NO TALK/ ALL TALK** | 10. NO TALK/ALL TALK: silence, confusion, pauses, short periods of silence, laughter, board work, pandemonium where observer cannot tell who is talking or cannot understand communication. |

**Figure 1.** Summary of categories for interaction analysis. Used with permission from *The Role of the Teacher in the Classroom*, 1967, by E.J. Amidon and N.A. Flanders. Minneapolis, MN. Association for Productive Teaching.

In order to make total interaction in the classroom meaningful, FIAS also provided for the categorizing of student talk (categories eight and nine). Student talk is divided into only two categories: (8) response and (9) initiation. The last category, (10) No talk/all talk, is included in order to account for the time spent in behavior other than that which can be classified as either teacher or student talk.

All statements that occur in the classroom then are categorized as either (a) teacher talk, (b) student talk, or (c) silence or confusion. The latter is used to handle anything else that is not teacher or student talk. All categories are mutually exclusive, yet totally inclusive of all verbal interaction occurring in the classroom.

Category 10 requires additional explanation. Different types of silence are (a) a short silence when a student is trying to think of an answer to a question and (b) a short silence or confusion indicating that the student does not understand the question, or does not know how or where to find the answer. An important point to note is that long silences because of student work on materials are not a part of FIAS. Additional types of confusion are the confusion of disorder and disruption and the constructive type of confusion.

## RECORDING OBSERVED INTERACTION BEHAVIOR

Every three seconds the observer is to record the category number of the observed interaction behaviors. He/she records these number in column sequence. The tempo should be kept steady and accurate. In addition, he/she should note the kind of lesson being taught and its purpose.

Here is an example to clarify the use of the FIAS. This example is a practicum class session in the first week during the organization and administration phase.

A graduate practicum class: The professor starts off with a lecture (5's), then asks a question (4). Student counselors think of the answer (10's). Student counselors are called upon (6's) at random to answer the question—several do (8's); the professor accepts their answers and clarifies them (3's), writing them on the chalkboard. The professor puts several correct examples on the chalkboard (5's) telling student counselors the correct manner to consider the issue (5's and 6's). The professor asks question (4), students give short answers (8's). Jack, a student counselor, interjected idea of his own (9's), professor criticized him (7's). The professor asks another question (4), receives short replies (8's). The professor praises class of attentiveness (2's), summarizes (5's), and gives assignment (6's) on which student counselors begin to work. At this point, the observation has ended.

The resulting list of recording looks somewhat like the list shown in Figure 5. Entries were made in columns from left to right. Note that a 10 is inserted as both the first entry (first number, left column) and the last entry (last number, right column): this is standard procedure, for we assume that each record begins and ends with silence.

## ORDERED PAIRS

These numbers from Figure 2 then are coupled into sequential pairs with the first number of each pair being the last number of the preceding pair. The results are shown in Figure 3. The first pair (10-5), second pair (5-5), third (5-5), fourth (5-5), fifth (5-10), sixth (10-4), seventh (4-10), and so on. These ordered pairs are not tabulated in the appropriate cells of a 10 x 10 matrix with row and column headings 1-10 (Figure 4). These headings 1-10 correspond with the code categories previously listed in Figure 1.

| | | | | |
|---|---|---|---|---|
| 10 | 4 | 8 | 8 | 8 |
| ) | ) | ) | ) | ) |
| 5 | 6 | 3 | 8 | 8 |
| ( | ( | ( | ( | ( |
| 5 | 8 | 3 | 9 | 2 |
| ) | ) | ) | ) | ) |
| 5 | 8 | 5 | 9 | 2 |
| ( | ( | ( | ( | ( |
| 5 | 8 | 5 | 7 | 5 |
| ) | ) | ) | ) | ) |
| 10 | 3 | 5 | 7 | 5 |
| ( | ( | ( | ( | ( |
| 4 | 3 | 6 | 10 | 5 |
| ) | ) | ) | ) | ) |
| 10 | 4 | 6 | 10 | 6 |
| ( | ( | ( | ( | ( |
| 10 | 6 | 4 | 4 | 6 |
| ) | ) | ) | ) | ) |
| 10 | 8 | 8 | 8 | 6 |
| | | | | ( |
| | | | | 10 |

**Figure 2.** Recorded observed interaction behaviors.

|  |  |  |  |  |
|---|---|---|---|---|
| 10-5 | 10-4 | 8-8 | 8-8 | 8-8 |
| 5-5 | 4-6 | 8-3 | 8-8 | 8-8 |
| 5-5 | 6-8 | 3-3 | 8-9 | 8-2 |
| 5-5 | 8-8 | 3-5 | 9-9 | 2-2 |
| 5-10 | 8-8 | 5-5 | 9-7 | 2-5 |
| 10-4 | 8-3 | 5-5 | 7-7 | 5-5 |
| 4-10 | 3-3 | 5-6 | 7-10 | 5-5 |
| 10-10 | 3-4 | 6-6 | 10-10 | 5-6 |
| 10-10 | 4-6 | 6-4 | 10-4 | 6-6 |
| 10-10 | 6-8 | 4-8 | 4-8 | 6-6 |
|  |  |  |  | 6-10 |

**Figure 3.** Ordered pairs based on observed interaction behaviors.

One entry is made in the matrix for each ordered pair of numbers listed. The first number in the ordered pair designates the row, and the second number designates the column. For example, with our first ordered pair (10-5) we look to row 10, then across to column 5 and make an entry, i.e., the first entry is at the intersection of row 10 and column 5. The seventh ordered pair (4-10) is entered in the matrix in the same manner. Look down to row 4 and across to columm 10, where the entry is made. When all the entries are made, total each of the columns, 1-10, and the overall total, as can be observed in Figure 4.

## ANALYSIS OF MATRIX ENTRIES

A brief analysis of the matrix indicates that the professor is responsible for 60 percent of the talk, and student counselors for 26 percent.

Specifically, this professor's talk time was spent in the following ways:

|  |  |
|---|---|
| Praising or encouraging | 4% |
| Accepting or using student counselors' ideas | 8% |
| Asking questions | 10% |
| Explaining or informing | 20% |
| Giving directions | 14% |
| Scolding, reprimanding, or defending authority | 4% |

The student counselor's talk time was as follows:

|  |  |
|---|---|
| Expected or predictable response | 22% |
| Initiated responses | 4% |

The use of a Verbal Interaction Analysis Technique (Flanders & Amidon, 1962) and several of its various adaptations by Amidon (1965), Altekruse and Brown (1969), and Mitchell (1971) have been shown to be a reliable means of evaluating counseling interview effectiveness.

## MITCHELL MODEL

In adapting this technique for evaluating the effectiveness of interviews of the student counselor, Mitchell (1971) first directed his attention toward developing categories of responses extant in counseling interviews. He surveyed verbal techniques used to develop the

|  | Columns |  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|
|  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | T |
| 1 |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  | 1 |  |  | 1 |  |  |  |  |  |  |
| 3 |  |  | 11 | 1 | 1 |  |  |  |  |  |  |
| 4 |  |  |  |  |  | 11 |  | 11 |  | 1 |  |
| 5 |  |  |  |  | 1111<br>111 | 11 |  |  |  | 1 |  |
| 6 |  |  |  | 1 |  | 111 |  | 11 |  | 1 |  |
| 7 |  |  |  |  |  |  | 1 |  |  | 1 |  |
| 8 |  | 1 | 11 |  |  |  |  | 1111<br>111 | 1 |  |  |
| 9 |  |  |  |  |  |  | 1 |  | 1 |  |  |
| 0 |  |  |  | 111 | 1 |  |  |  |  | 111 |  |
| T | 0 | 2 | 4 | 5 | 10 | 7 | 2 | 11 | 2 | 7 | 50 |
| % | 0 | 4 | 8 | 10 | 20 | 14 | 4 | 22 | 4 | 14 |  |

**Figure 4.** Overall total of categories from observation of practicum class.

counseling relationship in order to assign specific terms to be recorded and analyzed. Mitchell (1971) then arranged counselor response types into a series of classifications inclusive of possible interview responses yet exclusive by category. The *Mitchell model* is indicated in Figure 5.

An exploration of the categories summarized by Mitchell indicated that counselor talk in the first three classification is usually of an indirect nature while counselor talk in the fourth, fifth, and sixth categories would seem to identify more direct counselor involvement. We perceive the seventh category as usually being "out-of-touch" and therefore undesirable counselor behavior. When processing an audiotape of an interview with the student counselor, and a "7" occurs, we try to use an intervention defined by Redl and Wineman (1952) as "Tension-Decontamination Through Humor." This technique generally serves to relieve the embarrassment of the student counselor while simultaneously increasing awareness of unawareness.

Mitchell noted that the possibility of comparing the types of counselor response that elicits either type of client response is evident in addition to determining the frequencies of each category. No numeric value is assigned to the numbers representing the different categories, the numbers serve simply to identify the category for purposes of recording.

| | |
|---|---|
| **INDIRECT COUNSELOR TALK** | 1. Understanding, accepting<br>2. Reflecting, restating, clarifying<br>3. Interpreting, summarizing |
| **DIRECT COUNSELOR TALK** | 4. Answering, explaining, supporting reassuring, informing.<br>5. Probing questioning, searching, investigating.<br>6. Predicting, advising, directing, judging, moralizing. |
| **Out-of-Touch COUNSELOR TALK** | 7. Unawareness, non-understanding, squelch, innocuous statement, irrelevant response. |
| **CLIENT TALK** | 8. Client answers<br>9. Client initiates. |
| **OTHER** | 10. Silence. |

**Figure 5.** The Mitchell Model: Summary of categories for interaction analysis. Adapted from Mitchell, 1971.

## RECORDING BY THE MITCHELL MODEL

We use the Mitchell Model in this manner. The student counselor selects a seven minute segment from a previously recorded counseling interview. We play the tape, stopping it a five-second intervals to record counselor/client talk in a time space of two seconds. These data are recorded in columns from let to right, then converted to couplets and transferred to the matrix. The categories are totaled, and calculators quickly give us percentages of counselor and client verbal behavior for this segment of the interview.

Example of a seven minute segment of a counseling interview

**Co:** "Bob, with what problem would you like to deal?"

**Cl:** "My inability to establish a meaningful relationship with a woman."

**Co:** "Approximately how long have you been trying to establish such a relationship without success?"

**Cl:** "Since I was fifteen, and I am now 33."

**Co:** "So that's 18 years or so—and what do you think blocks you, because you obviously are handsome and you sound OK so far, now what do you think is your main barrier? What stops you?"

**Cl:** "My own insecurities at having been rejected by my mother."

**Co:** "All right—so you're saying that 'A' your mother rejected you, and let's assume that she did for the moment, we won't even argue that; therefore, you're unable to get accepted or to choose the woman you like and make it with a woman today, right?"

**Cl:** "Yes."

**Co:** "Now why is that baloney? 'Cause that's errant baloney, psychoanalytic baloney of the worst sort. Now, do *you* know why that's baloney?"

**Cl:** "Because I'm not unlovable. I know I'm not totally unlovable."

**Co:** "Right, but it's baloney because suppose we had a hundred males like you and they all were equally rejected by their mothers—let's just suppose that their mothers really did whatever your mother did, and they rejected them, and they all felt somewhat badly about it, because no one likes to be rejected—would all of them have difficulty relating to women today?"

**Cl:** "No."

**Co:** "No—you see, some of them would relate better. Do you know why they would?"

**Cl:** "No."

**Co:** "Because they'd say, 'Heck, I never made it with the old lady but I'll bet I make it with somebody.' You see that would give them an incentive! Now a lot of them wouldn't not make it for various reasons, but if you think about it you'll see it's never what happened to them in the past that stops them from making it today—it's what they told themselves and are still telling themselves about the past.

"Now how did you feel when your mother rejected you in the past?"

**Cl:** "Ah...I felt only unwanted."

**Co:** "All right. But would we call it depression or anxiety?"

**Cl:** "I felt depressed."

**Co:** "OK. You felt depressed. So at 'A,' the activating experience, your mother rejected you..."

The resulting list of recording by category of the previous seven minute segment of counseling interview according to the Mitchell Model are shown in Figure 6.

The numbers as shown in Figure 6 are then arranged in couplets and as ordered pairs as shown in Figure 7. The second number of each couplet is the first number in the next couplet

The second number of each couplet then is marked on the work matrix as a "simple 1." For instance the first couplet is "10-5." We move down to row 10 on the matrix, then move to the right to column 5, and place the mark "1" as shown in Figure 8.

| | | | | |
|---|---|---|---|---|
| 10 | | | | |
| 5 | 5 | 8 | 4 | 6 |
| 5 | 4 | 5 | 5 | 6 |
| 8 | 5 | 4 | 8 | 5 |
| 8 | 8 | 4 | 2 | 8 |
| 5 | 1 | 5 | 6 | 1 |
| 5 | 2 | 8 | 5 | 5 |
| 8 | 2 | 8 | 8 | 8 |
| 8 | 2 | 1 | 4 | 1 |
| 2 | 3 | 4 | 4 | 2 |
| 5 | 5 | 4 | 4 | 10 |

**Figure 6.** Seven minute counseling interview recorded by categories.

| | | | | |
|---|---|---|---|---|
| 10-5 | 5-5 | 5-8 | 4-4 | 4-6 |
| 5-5 | 5-4 | 8-5 | 4-5 | 6-6 |
| 5-8 | 4-5 | 5-4 | 5-8 | 6-5 |
| 8-8 | 5-8 | 4-4 | 8-2 | 5-8 |
| 8-5 | 8-1 | 4-5 | 2-6 | 8-1 |
| 5-5 | 1-2 | 5-8 | 6-5 | 1-5 |
| 5-8 | 2-2 | 8-8 | 5-8 | 5-8 |
| 8-8 | 2-2 | 8-1 | 8-4 | 8-1 |
| 8-2 | 2-3 | 1-4 | 4-4 | 1-2 |
| 2-5 | 3-5 | 4-4 | 4-4 | 2-10 |

**Figure 7.** Ordered pairs based on seven minute counseling interview.

| | Columns | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | T |
| 1 | | 11 | | 1 | 1 | | | | | | |
| 2 | | 11 | 1 | | 1 | 1 | | | | 1 | |
| 3 | | | | | 1 | | | | | | |
| 4 | | | | 111<br>11 | 111 | 1 | | | | | |
| 5 | | | | 11 | 111 | | | 11111<br>1111 | | | |
| 6 | | | | | 11 | 1 | | | | | |
| 7 | | | | | | | | | | | |
| 8 | 1111 | 11 | | 1 | 11 | | | 111 | | | |
| 9 | | | | | | | | | | | |
| 0 | | | | | 1 | | | | | | |
| T | 4 | 6 | 1 | 9 | 14 | 3 | 0 | 12 | 0 | 1 | 50 |
| % | 8 | 12 | 2 | 18 | 28 | 6 | 0 | 24 | 0 | 2 | |
| | Counselor Talk | | | | | | | Client Talk | | | |

**Figure 8.** Tabulated summary for the example of a seven minute segment of a counseling interview.

## SUMMARIZING AND ANALYZING BY THE MITCHELL WORK MATRIX

The summary by category of the information from the work matrix in Figure 8 follows:

1. Understanding, accepting = 8%
2. Reflecting, restating, clarifying = 12%
3. Interpreting, summarizing = 2%

Total Indirect Counselor Talk = 22%

4. Answering, explaining, supporting, reassuring, informing = 18%
5. Probing, questioning, searching, investigating = 28%
6. Predicting, advising, directing, judging, moralizing = 6%

Total Direct Counselor Talk = 52%

7. Unawareness, non-understanding squelch, innocuous statement irrelevant response = 0%
8. Client answers = 24%
9. Client initiates = 0%

Total Client Talk 24%

10. Silence = 2%

By examining these data we immediately noticed that our student counselor, Nell, had spent 28 percent of her talk time probing, questioning, searching, and investigating. We became aware that she spent 18 percent of her talk time answering, explaining, supporting, reassuring, and informing, and an additional 6 percent predicting, advising, and directing. Fifty-two percent of this segment was direct counselor talk. We also recognized that there are no "7's," that the counselor is not out-of-touch with the client. We were relieved to see that our counselor had spent 22 percent of her time in indirect counselor talk.

When we listened to content clues such as "That is errant psychoanalytical baloney," and "So at 'A,' the activating experience, your mother rejected you..." we being to understand that this student counselor is doing a good job of applying the techniques of Rational-Emotive Therapy, thus negating our concern that we might be dealing with a tyro counselor who is too pushy, not understanding, or acceptant of her client, and spending the majority of the time interrogating.

Our experience has been that the Mitchell system can be quickly learned and habituated for effective use by both student counselors and supervisors. As counselor educators, we felt a need to find ways to help student counselors to create a facilitative relationship of understanding, genuineness, warmth, and empathy. This adaptation of verbal interactional analysis is one technique that has given us and our student counselors success toward that end. We believe that you also will find the effort worthwhile.

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Redl, F., & Wineman, D. *Controls from within: Techniques for the treatment of the aggressive child.* New York: The Free Press, 1952.

Walters, R.P. Nonverbal communication in group counseling. In G.M. Gazda, *Group counseling: A developmental approach.* Boston: Allyn and Bacon, Inc., 1978.

■ ■ ■

## PEER RATING

Peer supervision and assessment have been identified as a valuable aid in the supervision process. This modality is recommended with some precautions. Peer supervision should be used only as a supplement to regular supervision and seems best utilized within the behavioral skill training approach. The peer supervisor can promote skill awareness through ratings and shared perceptions but an important procedure to follow is to make sure that if the peer supervision activities are initiated that they occur after group supervision has provided sufficient training and practice (Boyd, 1978). After a particular counseling skill has been introduced, modeled, and practiced within the group context, peer rating of counseling tapes can be implemented. We suggest that the peer critique of tapes be structured to focus on the rating of specific skills. For instance the target skill might be identified as one or more of the facilitative skills such as primary empathy, asking open ended questions or concreteness. Another target skill could be the recognition and handling of positive or negative affect, or the effective use of probes. Form 5.3, *Peer Rating Form*, has been included here to structure the use of peer rating activities.

### Reference

Boyd, J. (1978). The behavior approach to counselor supervision. In J. Boyd (Ed.), Counselor Supervision, pp. 89-132. Muncie, IN: Accelerated Development.

* * *

## SUPERVISOR MONITORING AND ASSESSMENT ACTIVITIES

Judith Scott

Assessment is provided by the supervisor at various times throughout the practicum and internship experiences. The first assessment occurs at the onset of supervision to facilitate a working alliance between the supervisor and supervisee and to establish mutually agreed upon goals. The supervisor is referred to the *Handbook on Clinical Supervision* (Borders & Leddick, 1987) for a review of standardized assessment and evaluation instruments which can be used for this purpose. The self assessment format included earlier in this Chapter (Form 5.1) has been presented as one approach to the goal setting process. The supervisor reviews and discusses awareness, knowledge, and practice in the categories of counseling performance skills, cognitive counseling skills, and developmental level of the trainee. Based on this dialogue and the use of standardized measures (if preferred), short-term and long-term goal statements can be formulated. We suggest that the goal statements be developed within the categories of performance skills, cognitive skills, and developmental level. These goal statements then become the context within which the professional development of the practicum student and intern can be interpreted. Progress toward goals can be reviewed at the mid-point and completion of each term of practicum and internship. Goals also can be renegotiated at the midpoint review to adjust for any special circumstances. A sample of a goal statement agreement is provided here. (See Sample 6.)

Continuing assessment of the student's work occurs regularly during the weekly individual and/or group supervision sessions conducted at both field site and university setting. In internship the student may be a fulltime intern in a location too far from campus for regular weekly meetings. However, the weekly or more often meetings with site-supervision will be held. An *Interview Rating Form* (Form 5.5) provides one approach to organizing and focusing the supervisor ratings of an individual session.

Two additional rating forms are included here to provide structured rating of the Trainee at the mid-point and end-points of practicum and/or internship. The *Site Supervisor's Evaluation of Student Counselor's Performances* (Form 5.6) is recommended for use at the midpoint of practicum/internship. This can be used as an adjunct to the *Goal Statement* review and can be interpreted within the goal statement categories. The more extensive *Counselor Competence Scale* (Form 5.7) is recommended for use at the endpoint of practicum/internship. This scale provides a broader array of performance and cognitive skills to be rated. We recommend use of this scale in addition to the final assessment of progress toward goal statement objectives.

### Reference

Borders, L.D., & Leddick, G. (1987). *Handbook of counseling supervision.* Alexandria, VA: Association for Counselor Education and Supervision.

## GOAL STATEMENT AGREEMENT

**Directions:** The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's Name: ____________ Supervisor's Name: ____________

Date submitted: ____________

### SHORT TERM GOALS

COUNSELING PERFORMANCE SKILLS: Demonstrate application of facilitative and challenging skills in client interviews.

COGNITIVE COUNSELING SKILLS: Demonstrate awareness in important client. information.

DEVELOPMENTAL LEVEL: Decrease anxiety concerning supervision.

### LONG TERM GOALS

COUNSELING PERFORMANCE SKILLS: Demonstrate ability to integrate and apply skills related to client self self exploration, goal setting and action.

COGNITIVE COUNSELING SKILLS: Demonstrate ability to analyze client and counselor interaction from at least one theoretical frame of reference.

DEVELOPMENTAL LEVEL: Demonstrate ability to collaborate and discuss with supervisor regarding appropriate application of an identified counseling method.

**Sample 6.** An example of a completed Goal Statement Agreement appropriate for a practicum student.

# SELF-RATING BY THE STUDENT COUNSELOR*

**SUGGESTED USE:** The student counselor may use this sheet as a self-evaluation after a therapy session.

Date: ____________ Client Name: ____________________ Student Counselor Name: ____________________

**DIRECTIONS:** The student counselor following a therapy session is to answer each question. The questions serve as a self-rating initiator and may enable the student counselor to determine means for improvement in his/her counseling.

**Preparation for the Interview**

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I physically in good condition and mentally alert? | | | |
| 2. Did I schedule sufficient time for the interview? | | | |
| 3. Was provision made for privacy and reasonable freedom from interruption? | | | |
| 4. Did I have the physical space arranged where we met so as to suggest welcome and an atmosphere conducive to counseling? | | | |
| 5. Did I have a background of available data about the client that would help me to understand him/her better in the interview but would not prejudice me? | | | |
| 6. Did I have and understand information so as to personalize information processes with the client? | | | |
| 7. Had I previously established a reputation for seeing the client's point of view, being genuinely helpful, and not disclosing confidences? | | | |

Comments:

**Beginning the Interview**

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I sensitive to the client and did I use an appropriate approach? | | | |
| 2. Was I able to create a psychological atmosphere in which the client was stimulated to take the responsibility of thinking through the situation? | | | |
| 3. Was I successful in maintaining open communication between us? | | | |

Comments:

---

*This material was taken from Kenneth Dimick and Frank Krause, *Practicum Manual in Counseling and Psychotherapy*. Muncie, IN: Accelerated Development Inc., 1980. Reprinted with permission.

### Development of the Interview

| | Yes | ? | No |
|---|---|---|---|
| 1. Did the client feel freedom to express negative feelings? | ___ | ___ | ___ |
| 2. Did the client have the opportunity to release tension? | ___ | ___ | ___ |
| 3. Was my attitude one of reflecting objectivity while expressing caring? | ___ | ___ | ___ |
| 4. Was I sincere and did I show genuine respect for the client? | ___ | ___ | ___ |
| 5. Was my own attitude, so far as I know, free from bias? | ___ | ___ | ___ |
| 6. Did I follow the leads suggested by the client? | ___ | ___ | ___ |
| 7. Did I help the client to clarify and expand positive feelings? | ___ | ___ | ___ |
| 8. Did the client establish a more forward looking, positive, hopeful attitude during the interview or series of interviews? | ___ | ___ | ___ |
| 9. Was I able to assist in information processing by the client? | ___ | ___ | ___ |
| 10. Was information provided in a manner which caused the client to move forward realistically in his/her thinking? | ___ | ___ | ___ |

Comments:

### Planning for Next Session

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I able to identify areas with which to follow through for the next session? | ___ | ___ | ___ |
| 2. Was I able to help client identify things to do between this interview and the next one? | ___ | ___ | ___ |
| 3. Was I able to help client gain a clear view of what might be done in the next session? | ___ | ___ | ___ |
| 4. Did I establish with the client a definite meeting time and place for the next session? | ___ | ___ | ___ |
| 5. Have I identified techniques that might be considered for the next session? | ___ | ___ | ___ |
| 6. Have I identified the materials and/or preparation I will need for the next session? | ___ | ___ | ___ |

Comments:

# SELF-RATING BY THE STUDENT COUNSELOR*

**SUGGESTED USE:** The student counselor may use this sheet as a self-evaluation after a therapy session.

Date: ____________ Client Name: ______________________ Student Counselor Name: ______________________

**DIRECTIONS:** The student counselor following a therapy session is to answer each question. The questions serve as a self-rating initiator and may enable the student counselor to determine means for improvement in his/her counseling.

**Preparation for the Interview**

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I physically in good condition and mentally alert? | _____ | _____ | _____ |
| 2. Did I schedule sufficient time for the interview? | _____ | _____ | _____ |
| 3. Was provision made for privacy and reasonable freedom from interruption? | _____ | _____ | _____ |
| 4. Did I have the physical space arranged where we met so as to suggest welcome and an atmosphere conducive to counseling? | _____ | _____ | _____ |
| 5. Did I have a background of available data about the client that would help me to understand him/her better in the interview but would not prejudice me? | _____ | _____ | _____ |
| 6. Did I have and understand information so as to personalize information processes with the client? | _____ | _____ | _____ |
| 7. Had I previously established a reputation for seeing the client's point of view, being genuinely helpful, and not disclosing confidences? | _____ | _____ | _____ |

Comments:

**Beginning the Interview**

| | | | |
|---|---|---|---|
| 1. Was I sensitive to the client and did I use an appropriate approach? | _____ | _____ | _____ |
| 2. Was I able to create a psychological atmosphere in which the client was stimulated to take the responsibility of thinking through the situation? | _____ | _____ | _____ |
| 3. Was I successful in maintaining open communication between us? | _____ | _____ | _____ |

Comments:

---

*This material was taken from Kenneth Dimick and Frank Krause, *Practicum Manual in Counseling and Psychotherapy*. Muncie, IN: Accelerated Development Inc., 1980. Reprinted with permission.

## Development of the Interview

| | Yes | ? | No |
|---|---|---|---|
| 1. Did the client feel freedom to express negative feelings? | | | |
| 2. Did the client have the opportunity to release tension? | | | |
| 3. Was my attitude one of reflecting objectivity while expressing caring? | | | |
| 4. Was I sincere and did I show genuine respect for the client? | | | |
| 5. Was my own attitude, so far as I know, free from bias? | | | |
| 6. Did I follow the leads suggested by the client? | | | |
| 7. Did I help the client to clarify and expand positive feelings? | | | |
| 8. Did the client establish a more forward looking, positive, hopeful attitude during the interview or series of interviews? | | | |
| 9. Was I able to assist in information processing by the client? | | | |
| 10. Was information provided in a manner which caused the client to move forward realistically in his/her thinking? | | | |

Comments:

## Planning for Next Session

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I able to identify areas with which to follow through for the next session? | | | |
| 2. Was I able to help client identify things to do between this interview and the next one? | | | |
| 3. Was I able to help client gain a clear view of what might be done in the next session? | | | |
| 4. Did I establish with the client a definite meeting time and place for the next session? | | | |
| 5. Have I identified techniques that might be considered for the next session? | | | |
| 6. Have I identified the materials and/or preparation I will need for the next session? | | | |

Comments:

# SELF-RATING BY THE STUDENT COUNSELOR*

**SUGGESTED USE:** The student counselor may use this sheet as a self-evaluation after a therapy session.

Date: ______________ Client Name: ____________________ Student Counselor Name: ____________________

**DIRECTIONS:** The student counselor following a therapy session is to answer each question. The questions serve as a self-rating initiator and may enable the student counselor to determine means for improvement in his/her counseling.

**Preparation for the Interview**

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I physically in good condition and mentally alert? | | | |
| 2. Did I schedule sufficient time for the interview? | | | |
| 3. Was provision made for privacy and reasonable freedom from interruption? | | | |
| 4. Did I have the physical space arranged where we met so as to suggest welcome and an atmosphere conducive to counseling? | | | |
| 5. Did I have a background of available data about the client that would help me to understand him/her better in the interview but would not prejudice me? | | | |
| 6. Did I have and understand information so as to personalize information processes with the client? | | | |
| 7. Had I previously established a reputation for seeing the client's point of view, being genuinely helpful, and not disclosing confidences? | | | |

Comments:

**Beginning the Interview**

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I sensitive to the client and did I use an appropriate approach? | | | |
| 2. Was I able to create a psychological atmosphere in which the client was stimulated to take the responsibility of thinking through the situation? | | | |
| 3. Was I successful in maintaining open communication between us? | | | |

Comments:

---

*This material was taken from Kenneth Dimick and Frank Krause, *Practicum Manual in Counseling and Psychotherapy*. Muncie, IN: Accelerated Development Inc., 1980. Reprinted with permission.

## Development of the Interview

| | Yes | ? | No |
|---|---|---|---|
| 1. Did the client feel freedom to express negative feelings? | | | |
| 2. Did the client have the opportunity to release tension? | | | |
| 3. Was my attitude one of reflecting objectivity while expressing caring? | | | |
| 4. Was I sincere and did I show genuine respect for the client? | | | |
| 5. Was my own attitude, so far as I know, free from bias? | | | |
| 6. Did I follow the leads suggested by the client? | | | |
| 7. Did I help the client to clarify and expand positive feelings? | | | |
| 8. Did the client establish a more forward looking, positive, hopeful attitude during the interview or series of interviews? | | | |
| 9. Was I able to assist in information processing by the client? | | | |
| 10. Was information provided in a manner which caused the client to move forward realistically in his/her thinking? | | | |

Comments:

## Planning for Next Session

| | Yes | ? | No |
|---|---|---|---|
| 1. Was I able to identify areas with which to follow through for the next session? | | | |
| 2. Was I able to help client identify things to do between this interview and the next one? | | | |
| 3. Was I able to help client gain a clear view of what might be done in the next session? | | | |
| 4. Did I establish with the client a definite meeting time and place for the next session? | | | |
| 5. Have I identified techniques that might be considered for the next session? | | | |
| 6. Have I identified the materials and/or preparation I will need for the next session? | | | |

Comments:

## PEER RATING FORM

**Purposes:** 1. To provide trainee with additional sources of feedback regarding skill development.

2. To provide rater with opportunity to increase knowledge and recognition of positive skill behavior.

**Directions:** 1. Trainee submits this sheet once a week to be completed by peer who reviews the trainee's tapes. The particular skills the counselor is working on are identified by the counselor trainee.

2. Peer writes remarks once a week on all tapes reviewed rating performance on the targeted skill behavior.

3. Information is cumulative to aid in review of progress.

---

Counselor's Name: ______________________________

Targeted Skills (to be identified by counselor):

**Remarks (based on all tapes reviewed during the week):**

Signature of Rater: ______________________ Date: __________

## PEER RATING FORM

**Purposes:** 1. To provide trainee with additional sources of feedback regarding skill development.

2. To provide rater with opportunity to increase knowledge and recognition of positive skill behavior.

**Directions:** 1. Trainee submits this sheet once a week to be completed by peer who reviews the trainee's tapes. The particular skills the counselor is working on are identified by the counselor trainee.

2. Peer writes remarks once a week on all tapes reviewed rating performance on the targeted skill behavior.

3. Information is cumulative to aid in review of progress.

---

Counselor's Name: ______________________________

Targeted Skills (to be identified by counselor):

**Remarks (based on all tapes reviewed during the week):**

**Signature of Rater:** ______________________ Date: __________

## PEER RATING FORM

**Purposes:**
1. To provide trainee with additional sources of feedback regarding skill development.
2. To provide rater with opportunity to increase knowledge and recognition of positive skill behavior.

**Directions:**
1. Trainee submits this sheet once a week to be completed by peer who reviews the trainee's tapes. The particular skills the counselor is working on are identified by the counselor trainee.
2. Peer writes remarks once a week on all tapes reviewed rating performance on the targeted skill behavior.
3. Information is cumulative to aid in review of progress.

---

Counselor's Name: ____________________

Targeted Skills (to be identified by counselor):

Remarks (based on all tapes reviewed during the week):

Signature of Rater: ____________________ Date: __________

## PEER RATING FORM

**Purposes:**
1. To provide trainee with additional sources of feedback regarding skill development.
2. To provide rater with opportunity to increase knowledge and recognition of positive skill behavior.

**Directions:**
1. Trainee submits this sheet once a week to be completed by peer who reviews the trainee's tapes. The particular skills the counselor is working on are identified by the counselor trainee.
2. Peer writes remarks once a week on all tapes reviewed rating performance on the targeted skill behavior.
3. Information is cumulative to aid in review of progress.

Counselor's Name: ____________________

Targeted Skills (to be identified by counselor):

Remarks (based on all tapes reviewed during the week):

Signature of Rater: ____________________ Date: __________

## GOAL STATEMENT AGREEMENT

**Directions:** The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's Name: ____________________ Supervisor's Name: ____________________

Date submitted: ____________________

### SHORT TERM GOALS

COUNSELING PERFORMANCE SKILLS: ____________________

COGNITIVE COUNSELING SKILLS: ____________________

DEVELOPMENTAL LEVEL: ____________________

GOAL STATEMENT AGREEMENT

Directions: The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's Name: ____________________ Supervisor's Name: ____________________

Date submitted: ____________________

SHORT TERM GOALS

COUNSELING PERFORMANCE SKILLS: ____________________

COGNITIVE COUNSELING SKILLS: ____________________

DEVELOPMENTAL LEVEL: ____________________

## LONG TERM GOALS

COUNSELING PERFORMANCE SKILLS:

COGNITIVE COUNSELING SKILLS:

DEVELOPMENTAL LEVEL:

LONG TERM GOALS

COUNSELING PERFORMANCE SKILLS:

COGNITIVE COUNSELING SKILLS:

DEVELOPMENTAL LEVEL:

## GOAL STATEMENT AGREEMENT

**Directions:** The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's Name: ____________________ Supervisor's Name: ____________________

Date submitted: ____________________

### SHORT TERM GOALS

COUNSELING PERFORMANCE SKILLS: ____________________

COGNITIVE COUNSELING SKILLS: ____________________

DEVELOPMENTAL LEVEL: ____________________

GOAL STATEMENT AGREEMENT

Directions: The student completes the agreement in duplicate and submits one copy to the supervisor.

Student's Name: ____________________ Supervisor's Name: ____________________

Date submitted: ____________________

SHORT TERM GOALS

COUNSELING PERFORMANCE SKILLS: ____________________

COGNITIVE COUNSELING SKILLS: ____________________

DEVELOPMENTAL LEVEL: ____________________

Form 5.4, p.1 of 2, Copy 3 & 4

## LONG TERM GOALS

COUNSELING PERFORMANCE SKILLS: ______________________________

______________________________

______________________________

COGNITIVE COUNSELING SKILLS: ______________________________

______________________________

______________________________

DEVELOPMENTAL LEVEL: ______________________________

______________________________

______________________________

## LONG TERM GOALS

COUNSELING PERFORMANCE SKILLS: ______________________________

______________________________

______________________________

COGNITIVE COUNSELING SKILLS: ______________________________

______________________________

______________________________

DEVELOPMENTAL LEVEL: ______________________________

______________________________

______________________________

# INTERVIEW RATING

**Rating of a Counseling Session Conducted by a Student Counselor**

Gordon Poling*

Client Name or Identification: ______________________ Student Counselor Name: ______________________

CHECK ONE

_________ Audio Tape
_________ Video Tape
_________ Observation
_________ Other (Specify)__________

Signature of Supervisor or Observer ______________________

Date of Interview: ______________________

**DIRECTIONS:** Supervisor or peer of the student counselor is to mark a rating for each item and as much as possible is to provide remarks that will help the student counselor in his/her development.

| SPECIFIC CRITERIA | RATING (best to least) | REMARKS |
|---|---|---|
| 1. OPENING: Was opening unstructured, friendly, and pleasant? Any role definition needed? Any introduction necessary? | 5 4 3 2 1 | |
| 2. RAPPORT: Did student counselor establish good rapport with client? Was the stage set for a productive interview? | 5 4 3 2 1 | |
| 3. INTERVIEW RESPONSIBILITY: If not assumed by the client, did student counselor assume appropriate level of responsiblity for interview conduct? Did student counselor or client take initiative? | 5 4 3 2 1 | |
| 4. INTERACTION: Were the client and student counselor really communicating in a meaningful manner. | 5 4 3 2 1 | |
| 5. ACCEPTANCE/PERMISSIVENESS: Was the student counselor accepting and permissive of client's emotions, feelings, and expressed thoughts? | 5 4 3 2 1 | |
| 6. REFLECTIONS OF FEELINGS: Did student counselor reflect and react to feelings or did interview remain on an intellectual level? | 5 4 3 2 1 | |

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| SPECIFIC CRITERIA | RATING (best to least) | REMARKS |
|---|---|---|
| 7. STUDENT COUNSELOR RESPONSES: Were student counselor responses appropriate in view of what the client was expressing or were responses concerned with trivia and minutia? Meaningful questions? | 5 4 3 2 1 | |
| 8. VALUE MANAGEMENTS: How did the student counselor cope with values? Were attempts made to impose counselor values during the interview? | 5 4 3 2 1 | |
| 9. COUNSELING RELATIONSHIP: Were student counselor-client relationships conducive to productive counseling? Was a counseling relationship established? | 5 4 3 2 1 | |
| 10. CLOSING: Was closing student counselor or client initiated? Was it abrupt or brusque? Any follow-up or further interview scheduling accomplished? | 5 4 3 2 1 | |
| 11. GENERAL TECHNIQUES: How well did the student counselor conduct the mechanics of the interview?<br>A. Duration of interview: Was the interview too long or too short? Should interview have been terminated sooner or later?<br>B. Vocabulary level: Was student counselor vocabulary appropriate for the client?<br>C. Mannerisms: Did the student counselor display any mannerism which might have conversely affectd the interview or portions thereof?<br>D. Verbosity: Did the student counselor dominate the interview, interrupt, override, or become too wordy?<br>E. Silences: Were silences broken to meet student counselor needs or were they dealt with in an effectual manner? | 5 4 3 2 1 | |

**COMMENTS FOR STUDENT COUNSELOR ASSISTANCE:** Additional comments that might assist the student counselor in areas not covered by the preceding suggestions.

# SITE SUPERVISOR'S EVALUATION OF STUDENT COUNSELOR'S PERFORMANCE

**SUGGESTED USE:** This form is to be used to check performances in counseling practicum. The form may be completed after each supervised counseling session or may cover several supervisions over a period of time. The form is appropriate for individual or group counseling.

**ALTERNATE USE:** The student counselor may ask a peer to observe a counseling session and mark the evaluation.

Name of Student Counselor: ____________________________

Name or Identifying Code of Client: ____________________________

Date of Supervision: ______________ or Period Covered by the Evaluation: ______________

**DIRECTIONS:** The supervisor following each counseling session which has been supervised or after several supervisions covering a period of time is to circle a number which best evaluates the student counselor on each performance at that point in time.

| **General Supervision Comments** | **Poor** | **Adequate** | **Good** |
|---|---|---|---|
| 1. Demonstrates a personal commitment in developing professional competencies | 1 2 | 3 4 | 5 6 |
| 2. Invests time and energy in becoming a counselor | 1 2 | 3 4 | 5 6 |
| 3. Accepts and uses constructive criticism to enhance self-development and counseling skills | 1 2 | 3 4 | 5 6 |
| 4. Engages in open, comfortable, and clear communication with peers and supervisors | 1 2 | 3 4 | 5 6 |
| 5. Recognizes own competencies and skills and shares these with peers and supervisors | 1 2 | 3 4 | 5 6 |
| 6. Recognizes own deficiencies and actively works to overcome them with peers and supervisors | 1 2 | 3 4 | 5 6 |
| 7. Completes case reports and records punctually and conscientiously | 1 2 | 3 4 | 5 6 |
| **The Counseling Process** | | | |
| 8. Researchers the referral prior to the first interview | 1 2 | 3 4 | 5 6 |
| 9. Keeps appointments on time | 1 2 | 3 4 | 5 6 |
| 10. Begins the interview smoothly | 1 2 | 3 4 | 5 6 |
| 11. Explains the nature and objectives of counseling when appropriate | 1 2 | 3 4 | 5 6 |
| 12. Is relaxed and comfortable in the interview | 1 2 | 3 4 | 5 6 |
| 13. Communicates interest in and acceptance of the client | 1 2 | 3 4 | 5 6 |
| 14. Facilitates client expression of concerns and feelings | 1 2 | 3 4 | 5 6 |
| 15. Focuses on the content of the client's problem | 1 2 | 3 4 | 5 6 |
| 16. Recognizes and resists manipulation by the client | 1 2 | 3 4 | 5 6 |
| 17. Recognizes and deals with positive effect of the client | 1 2 | 3 4 | 5 6 |
| 18. Recognizes and deals with negative effect of the client | 1 2 | 3 4 | 5 6 |
| 19. Is spontaneous in the interview | 1 2 | 3 4 | 5 6 |
| 20. Uses silence effectively in the interview | 1 2 | 3 4 | 5 6 |
| 21. Is aware of own feelings in the counseling session | 1 2 | 3 4 | 5 6 |
| 22. Communicates own feelings to the client when appropriate | 1 2 | 3 4 | 5 6 |

---

**Reprinted by permission from Dr. Harold Hackney, Assistant Professor, Purdue University. This form was designed by two graduate students based upon material from *Counseling Strategies and Objectives* by H. Hackney and S. Nye, Prentice-Hall, 1973. This material was taken from chapter entitled "Evaluation of Student Counselors and Supervisors," pp. 265-274, in Kenneth Dimick and Frank Krause (Eds.), *Practicum Manual in Counseling and Psychotherapy*, Muncie, IN: Accelerated Development Inc.**

| The Counseling Process (Continued) | Poor | Adequate | Good |
|---|---|---|---|
| 23. Recognizes and skillfully interprets the client's covert messages | 1 2 | 3 4 | 5 6 |
| 24. Facilitates realistic goal-setting with the client | 1 2 | 3 4 | 5 6 |
| 25. Encourages appropriate action-step planning with the client | 1 2 | 3 4 | 5 6 |
| 26. Enjoys judgment in the timing and use of different techniques | 1 2 | 3 4 | 5 6 |
| 27. Initiates periodic evaluation of goals, action-steps, and process during counseling | 1 2 | 3 4 | 5 6 |
| 28. Explains, administers, and interprets tests correctly | 1 2 | 3 4 | 5 6 |
| 29. Terminates the interview smoothly | 1 2 | 3 4 | 5 6 |

## The Conceptualization Process

|  |  |  |  |
|---|---|---|---|
| 30. Focuses on specific behaviors and their consequences, implications, and contingencies | 1 2 | 3 4 | 5 6 |
| 31. Recognizes and pursues discrepancies and meaning of inconsistent information | 1 2 | 3 4 | 5 6 |
| 32. Use relevant case data in planning both immediate and long-range goals | 1 2 | 3 4 | 5 6 |
| 33. Uses relevant case data in considering various strategies and their implication | 1 2 | 3 4 | 5 6 |
| 34. Bases decisions on a theoretically sound and consistent rationale of human behavior | 1 2 | 3 4 | 5 6 |
|  | 1 2 | 3 4 | 5 6 |
| 35. Is perceptive in evaluating the effects of own counseling techniques | 1 2 | 3 4 | 5 6 |
| 36. Demonstrates ethical behavior in the counseling activity and case management | 1 2 | 3 4 | 5 6 |

Additional Comments and/or Suggestions: ________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Date: ______________________ Signature of Supervisor ______________________

or Peer ______________________ __________

My signature indicates that I have read the above report and have discussed the content with my site supervisor. It does not necessarily indicate that I agree with the report in part or in whole.

Date: ______________________ Signature of Student Counselor: ______________________

# COUNSELOR COMPETENCY SCALE*

For the Analysis And Assessment of Counselor Competencies

This scale is an altered version of the "Survey of Counselor Competencies" developed by Dennis B. Cogan, Department of Counselor Education, Arizona State University, Tempe, Arizona 85282.

| COUNSELOR COMPETENCY | ANALYSIS Skill Value to Interview | | | ASSESSMENT Proficiency | |
|---|---|---|---|---|---|
| | Critical | Important | Non-Essential | + | - |
| PERSONAL CHARACTERISTICS | | | | | |
| 1. SOCIAL RESPONSIBLITY--the counselor states, and his/her past experiences show, that he /she is interested in social change. | | | | | |
| 2. PEOPLE ORIENTED--the counselor is people oriented as demonstrated by his/her past experiences and by his/her present social interactions. | | | | | |
| 3. FALLIBILITY--the counselor recognizes that he/she is not free from making errors. | | | | | |
| 4. PERSONAL PROBLEMS--the counselor's personal problems are kept out of the counseling session. | | | | | |
| 5. MODELING--the counselor models appropriate cognitive processes, behaviors, and feelings during the counseling session. | | | | | |
| 6. NON-DEFENSIVE--the counselor gives and receives feedback to and from his/her clients, peers, and supervisor without making excuses or justifications | | | | | |
| Other: ______ | | | | | |
| Other: ______ | | | | | |
| Other: ______ | | | | | |
| PHILOSOPHICAL FOUNDATIONS | | | | | |
| 7. EVALUATION--the counselor's theoretical frame of reference includes a means for describing the cognitive, behavioral and/or affective change(s) that take place in determining the effectiveness of the selected counseling strategy. | | | | | |
| 8. DIAGNOSIS--regardless of his/her theoretical orientation, the counselor can identify maladaptive symptomology consistent with his/her theoretical frame of reference. | | | | | |
| 9. THEORY--the counselor states his/her assumptions about human behavior, through which he/she will incorporate or abstract his/her empirical findings and through which he/she will make predictions concerning his/her client. | | | | | |

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*This material was taken from Appendix A, pp. 482-490 in John Boyd (Ed.), *Counselor Supervision*, Muncie, IN: Accelerated Development Inc., 1978. Reprinted by permission.

| **COUNSELOR COMPETENCY** | **ANALYSIS** Skill Value to Interview | | | **ASSESSMENT** Proficiency | |
|---|---|---|---|---|---|
| | Critical | Important | Non-Essential | + | - |
| 10. THEORY--the counselor explains human behavior from at least two theories of personality. | | | | | |
| 11. PRIORITIZING--the counselor decides on which problem, when presented with more than one, to deal with first according to his/her theoretical frame of reference. | | | | | |
| 12. INTERPRETATION--the counselor provides the client with a possible explanation for or relationships between certain behaviors, cognitions, and/or feelings. | | | | | |
| 13. PROGNOSIS--the counselor can make an evaluation of the client's potential for successful treatment consistent with theoretical frame of reference. | | | | | |
| 14. INTERACTIONS——the counselor describes the interactions that take place between the counselor and client consistent with his/her theoretical frame of reference. | | | | | |
| 15. DEFENSE MECHANISMS--the counselor is aware of the defense mechanisms used by the client, the purpose they serve, and can help the client substitute more appropriate ones. | | | | | |
| 16. CATHARSIS--the counselor understands the concept of cathrarsis. | | | | | |
| 17. NATURAL CONSEQUENCES--the counselor understands the concept of "natural consequences." | | | | | |
| 18. ENVIRONMENTAL MANIPULATION--the counselor understands the concept of environmental manipulation. | | | | | |
| 19. TEST SELECTION--the counselor selects an appropriate test(s) according to his/her theorectical frame of reference. | | | | | |
| 20. INFERENCES--the counselor provides an explanation for and the functional use of the client's behaviors, cognitions, and/or feelings consistent with his/her theoretical frame of refernce and how they might influence the counseling process. | | | | | |
| Other: ______________________________ | | | | | |
| Other: ______________________________ | | | | | |
| Other: ______________________________ | | | | | |

| **COUNSELOR COMPETENCY** | **ANALYSIS**<br>Skill Value to Interview | | | **ASSESSMENT**<br>Proficiency | |
|---|---|---|---|---|---|
| COMMUNICATIONS | Critical | Important | Non-Essential | + | - |
| 21. OPEN-ENDED QUESTION--the counselor asks the client a question that cannot be answered by a yes or no, and the question does not provide the client with the answer. | | | | | |
| 22. MINIMAL VERBAL RESPONSE--the counselor uses "mmmh, oh, yes" to communicate to the client that he/she is listening, without interrupting the client's train of thought or discourse. | | | | | |
| 23. GENUINENESS--the counselor's responses are sincere and appropriate. | | | | | |
| 24. POSITIVE REGARD--without interjecting his/her own values, the counselor communicates respect and concern for the client's feelings, experiences, and potentials. | | | | | |
| 25. LANGUAGE--the counselor uses terminology that is understood by the client. | | | | | |
| 26. CLARIFICATION--the counselor has the client clarify vague and ambiguous cognitions, behaviors, and/or feelings. | | | | | |
| 27. PARAPHRASING--without changing the meaning, the counselor states in fewer words what the client has previously stated. | | | | | |
| 28. SUMMARIZES--the counselor combines two or more of the client's cognitions, feelings, and/or behaviors into a general statement. | | | | | |
| 29. RESTATEMENT--the counselor conveys to the client that he/she has heard the content of the client's previous statement(s) by restaing in exactly or near exact words, that which the client has just verbalized. | | | | | |
| 30. EMPATHIC UNDERSTANDING--the counselor's responses add noticeably to the expressions of the client in such a way as to express feelings at a level deeper than the client was able to express for himself/herself. | | | | | |
| 31. REFLECTION--from nonverbal cues the counselor accurately describes the client's affective state. | | | | | |
| 32. PERCEPTIONS--the counselor labeled his/her perceptions as perceptions. | | | | | |
| 33. CONFRONTATION--the counselor confronts the client by stating the possible consequences of his/her behaviors, cognitions, and/or feelings. | | | | | |

| COUNSELOR COMPETENCY | ANALYSIS Skill Value to Interview | | | ASSESSMENT Proficiency | |
|---|---|---|---|---|---|
| | Non-Essential | Important | Critical | + | - |
| 34. SUPPORTIVE--the counselor makes statements that agree with the client's cognitions, accepts the client's behavior, and/or shares with the client that his/her feelings were not unusual. | | | | | |
| 35. PROBING--the counselor's statement results in the client providing additional information about his/her cognitions, behaviors, and/or feelings. | | | | | |
| 36. DISAPPROVAL--the counselor makes a statement that conveys disapproval of one or more of the client's cognitions, behaviors, and/or feelings. | | | | | |
| 37. ADVICE GIVING--the counselor shares with the client which alternative he/she would select if it were his/her decision to make. | | | | | |
| Other ______________________________ | | | | | |
| Other ______________________________ | | | | | |
| Other ______________________________ | | | | | |
| COUNSELING SKILLS | | | | | |
| 38. VOICE--the counselor's tone of voice and rate of speech is appropriate to the client's present state and/or counseling session. | | | | | |
| 39. EYE CONTACT--the counselor maintains eye contact at a level that is comfortable for the client. | | | | | |
| 40. INITIAL CONTACT--the counselor greets the client in a warm and accepting manner through some accepted form of social greeting (handshake, nod of head, etc.) | | | | | |
| 41. ACTIVITY LEVEL--the counselor maintains a level of activity appropriate to the client during the counseling session. | | | | | |
| 42. PHYSIOLOGICAL PRESENCE--the counselor's body posture, facial expresions, and gestures are natural and congruent with those of the client's. | | | | | |
| 43. COUNSELOR DISCLOSURE--the counselor shares personal information and feelings when it is appropriate in facilitating the counseling process. | | | | | |
| 44. SILENCE--the counselor does not speak when appropriate in facilitating client movement. | | | | | |

| COUNSELOR COMPETENCY | **ANALYSIS** Skill Value to Interview | | | **ASSESSMENT** Proficiency | |
|---|---|---|---|---|---|
| | Non-Essential | Important | Critical | + | - |
| 45. ACCENTING--from the client's previous statement, behavior, and/or feeling, the counselor repeats or accentuates the same, or has the client repeat or acccentuate the statement, behavior, and/or feeling. | ___ | ___ | ___ | ___ | ___ |
| 46. OBJECTIVITY--the counselor has sufficient control over his/her feelings and does not impose his/her values on the client. | ___ | ___ | ___ | ___ | ___ |
| 47. PROBING--the counselor avoids bringing up or pursuing areas that are too threatening to the client. | ___ | ___ | ___ | ___ | ___ |
| 48. RESISTANCE--the counselor is able to work through the client's conscious and/or unconscious opposition to the counseling process. | ___ | ___ | ___ | ___ | ___ |
| 49. VERBOSITY--the counselor speaks when it is necessary, does not inappropriately interrupt the client or verbally dominate the counseling session. | ___ | ___ | ___ | ___ | ___ |
| 50. ATTENDING--the counselor's attention is with the client's cognitions, behaviors, and/or feelings during the counseling session in accord with his/her stated theoretical frame of reference. | | | | | |
| 51. TRANSFERENCE--the counselor is able to work through feelings directed at him/her by the client which the client originally had for another object or person. | ___ | ___ | ___ | ___ | ___ |
| 52. COUNTER-TRANSFERENCE--the counselor is aware of and is able to correct his/her placing his/her own wishes on the client. | ___ | ___ | ___ | ___ | ___ |
| 53. MANIPULATION--the counselor recognizes the client's attempt at influencing the counselor for his/her own purpose. | ___ | ___ | ___ | ___ | ___ |
| 54. FACTORS--the counselor explores and is aware of socio-economic, cultural, and personal factors that might affect the client's progress. | ___ | ___ | ___ | ___ | ___ |
| 55. DEPENDENCY--the counselor encourages the client to be independent, does not make decisions for the client or accept responsibility for the client's behaviors, cognitions, and/or feelings. | ___ | ___ | ___ | ___ | ___ |
| 56. THEORY--the counsleor can work with clients from at least two theories of counseling. | ___ | ___ | ___ | ___ | ___ |
| 57. ALTERNATIVE EXPLORATION--the counselor, with the client, examines the other options available and the possible consequences of each. | ___ | ___ | ___ | ___ | ___ |

| COUNSELOR COMPETENCY | **ANALYSIS** Skill Value to Interview | | | **ASSESSMENT** Proficiency | |
|---|---|---|---|---|---|
| | Non-Essential | Important | Critical | + | - |
| 58. IMPLEMENTATION--the counselor helps the client put insight into action. | | | | | |
| 59. DISTORTIONS--the counselor explains to the client his/her previously distorted perceptions of self and the environment. | | | | | |
| 60. MOTIVATION--the counselor can verbally confront the client with his/her lack of goal directed behavior. | | | | | |
| 61. CASE HISTORY TAKING--the counselor obtains factual information from the client that will be helpful in developing a course of action for the client consistent with his/her theoretical frame of reference. | | | | | |
| 62. INSIGHT--the counselor helps the client become more aware of his/her cognitive, behavioral, affective, and spiritural domain. | | | | | |
| 63. STRUCTURE--the counselor structures the on-going counseling sessions so there is continuity from session to session. | | | | | |
| 64. INCONSISTENCIES--the counselor identifies and explores with the client contraditions within and/or between client behaviors, cognitions, and/or affect. | | | | | |
| 65. RE-FOCUSING--the counselor makes a statement or asks a question that redirects the client to a specific behavior, cognition, or feeling. | | | | | |
| 66. GOALS--the counselor, with the client, establishes short and long range goals which are congruent with societal goals and are within the client's potential. | | | | | |
| 67. REINFORCEMENT--the counselor identifies and uses reinforcers that facilitate the identified client goals. | | | | | |
| 68. FLEXIBILITY--the counselor changes long and short term goals within a specific session or during the overall counseling process as additional information becomes available. | | | | | |
| 69. BEHAVIORAL GAME--the counselor can develop specific plans, that can be observed and/or counted, for changing the client's behavior(s). | | | | | |
| 70. STRATEGY--the counselor's course of action is consistent with the counselor's stated theory of counseling. | | | | | |
| 71. TERMINATION--the counselor resolves the client's desire for premature termination. | | | | | |

| COUNSELOR COMPETENCY | **ANALYSIS** Skill Value to Interview | | | **ASSESSMENT** Proficiency | |
|---|---|---|---|---|---|
| | Critical | Important | Non-Essential | + | - |
| 72. EMERGENCIES--the counselor can handle emergencies that arise with the client. | | | | | |
| 73. TERMINATION--the counselor ends each session and the counseling relationship on time or at a point at which the client is comfortable with the issues that have been explored. | | | | | |
| 74. TERMINATION--the counselor advises the client that he/she may return in the future. | | | | | |
| 75. PERIODIC EVALUATION--with the client, the counselor periodically evaluates the progress made toward the established goals. | | | | | |
| 76. FANTASY--the counselor has the client use his/her imagination to gain insight and/or move toward the client's established goals. | | | | | |
| 77. HOMEWORK--the counselor appropriately assigns work to the client that is to be completed outside the counseling session. | | | | | |
| 78. PROBLEM SOLVING--the counselor teaches the client a method for problem solving. | | | | | |
| 79. TEST INTERPRETATION--the counselor interprets test(s) according to the procedures outlined in the test manual. | | | | | |
| 80. ROLE PLAYING--the counselor helps the client achieve insight by acting out conflicts and/or situations unfamiliar to him/her. | | | | | |
| 81. DESENSITIZATION--the counselor can apply a purposeful technique to reduce the level of anxiety that the client is experiencing. | | | | | |
| 82. DREAMS--the counselor works with client's dreams in a manner consistent with his/her stated theoretical frame of reference. | | | | | |
| 83. CONTRACTS--the counselor makes a contratual agreement with the client. | | | | | |
| Other ______________________ | | | | | |
| Other ______________________ | | | | | |
| Other ______________________ | | | | | |

| COUNSELOR COMPETENCY | ANALYSIS<br>Skill Value to Interview | | | ASSESSMENT<br>Proficiency | |
|---|---|---|---|---|---|
| ADJUNCTIVE ACTIVITIES | Non-Essential | Important | Critical | + | - |
| 84. CASE NOTES--the counselor is able to communicate in writing in a clear and concise manner initial, ongoing, and summary case notes. | ____ | ____ | ____ | ____ | ____ |
| 85. STAFFING--the counselor can staff a case in a clear and concise manner by presenting an objective description of the client, significant information, goals for the client, strategy to be used, and a prognosis for the client. | ____ | ____ | ____ | ____ | ____ |
| 86. TEST ADMINISTRATION--the counselor can administer test(s) according to the procedures in the test manual. | ____ | ____ | ____ | ____ | ____ |
| 87. DIAGNOSIS--the counselor identifies cognitions, behaviors, and/or feelings in the client important in making a diagnosis according to the Diagnositic and Statistical Manual of Mental Disorders II. | ____ | ____ | ____ | ____ | ____ |
| 88. APPOINTMENTS--the counselor is on time for his/her appointments with clients, peers, and supervisors. | ____ | ____ | ____ | ____ | ____ |
| 89. INFORMS--the counselor provides the client with factual information. | ____ | ____ | ____ | ____ | ____ |
| 90. ORGANIZED--the counselor effectively organizes and completes the assigned work within the prescribed time limits of the setting in which he/she is employed. | ____ | ____ | ____ | ____ | ____ |
| 91. DRESS--the counselor's attire is appropriate to the client population and work setting being served. | ____ | ____ | ____ | ____ | ____ |
| 92. RESPONSIBLITIES--the counselor can clarify the role and responsibilities he/she and the client have in the counseling relationship according to his/her theoretical frame of reference. | ____ | ____ | ____ | ____ | ____ |
| 93. ATMOSPHERE--within the limits of his/her work setting, the counselor provides an atmosphere that is physically and psychologically comfortable for the client. | ____ | ____ | ____ | ____ | ____ |
| 94. CANCELLATIONS--the counselor notifies the client as soon as possible when he/she will be unable to keep an appointment. | ____ | ____ | ____ | ____ | ____ |

| **COUNSELOR COMPETENCY** | **ANALYSIS**<br>Skill Value to Interview | | | **ASSESSMENT**<br>Proficiency | |
|---|---|---|---|---|---|
| | Critical | Important | Non-Essential | + | - |
| 95. COMPETENCY--the counselor is aware of and does not go beyond his/her counseling abilities. | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |
| ETHICAL STANDARDS | | | | | |
| 96. PROFESSIONALISM--the counselor maintains a professional relationship with the client in accord with APA and/or APGA ethical standards. | ____ | ____ | ____ | ____ | ____ |
| 97. ETHICS--the counselor adheres to the ethical standards outlined by the APA and/or APGA. | ____ | ____ | ____ | ____ | ____ |
| 98. CONFIDENTIALITY--the counselor adheres to the ethical standards of confidentiality as outlined by the APA and/or APGA. | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |
| Other ________________ | ____ | ____ | ____ | ____ | ____ |

# NOTES

CHAPTER **6**

# ETHICAL AND LEGAL GUIDELINES

**In Chapter six are addressed the ethical and legal definitions of confidentiality, privileged communication, and informed consent. It also apprises the practicum students and interns of the rapidly changing nature of these concepts due to new legal mandates. Representative ethical codes also are presented in this chapter. The practicum student and intern should refer to these codes when information is needed regarding the ethical issues encountered in their training.**

* * *

## CONFIDENTIALITY, PRIVILEGED COMMUNICATION, AND INFORMED CONSENT

Patrick B. Malley

*Confidentiality* has long been considered an integral part of the helping professional's role with his/her clients. Most therapists agree that maintaining a right to privacy is a basic ingredient to maintaining human dignity. Client's rights to confidentiality are reflected in all of the ethical codes, some of which are exemplified in the following:

Summary of Ethical Codes on Confidentiality American Psychiatric Association (1981):

> Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment.
>
> A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion.
>
> Clinical and other material used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

National Association of Social Workers (1980):

> The social worker should share with others confidences revealed by clients, without their consent, only for compelling professional reasons.
>
> The social worker should inform clients fully about the limits of confidentiality in a given situation, the purposes for which information is obtained, and how it may be used.

Standards for the Private Practice of Clinical Social Work (NASW, 1981):

> The clinical social worker in private practice may find it necessary to reveal confidential information disclosed by the patient to protect the patient or the community from imminent danger.
>
> When the clinical social worker in private practice is ordered by the court to reveal the confidences entrusted by patients, the practitioner may comply or may ethically hold the right to dissent within the framework of the law.

American Association for Marriage and Family Therapy (1981):

> The therapist is responsible for informing clients of the limits of confidentiality.
>
> Written permission shall be granted by clients involved before data may be divulged.
>
> Information is not communicated to others without consent of the client unless there is clear and immediate danger to an individual or to society, and then only to the appropriate family members, professional workers, or public authorities.

American Psychological Association (1981):

> Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.

The origins of confidentiality in the therapeutic relationship came initially from the physician-patient relationship (Denkowski & Denkowski, 1982). The state of New York in 1828 was the first to legislate that patients had a right to confidentiality (Slovenko, 1973). Through the next one hundred years, most of the states came to this recognition also. Since psychiatrists were medical doctors, this confidential mandate was also extended to them in their therapeutic endeavors. Finally, therapists, who were not medical doctors, were included in the context of those who, by law, and by ethical mandate included confidentiality as part of the client/therapist contract. Today those in the helping professions regard confidentiality as primary constituent factor in the therapeutic relationship.

Confidentiality was initially defined as a professional ethic under which the client is protected from unauthorized disclosures by the professional without the consent of the client. Confidentiality is an explicit contract between the therapist and client to reveal nothing about the client except under conditions agreed to by the client (Siegel, 1979).

Initially many professionals believed that in order for counseling relationships to be beneficial an absolute standard of confidentiality had to be adhered to (Hollander, 1965). As time progressed, viewing confidentiality as an absolute construct became increasingly more difficult both from an ethical and legal standpoint; and those in the helping professions began to view it as limited rather than absolute. Probably legal mandates provided the impetus for the change in the ethical codes. The primary legal constraints which have had influence on how confidentiality in therapeutic relationship is construed are as follows:

1. The Tarasoff Case. The California Supreme Court rules that therapists may need to break confidentiality to protect others who are in eminent danger.
2. Law suits brought against doctors and institutions for not providing adequate care for suicidal patients.
3. The enactment of child abuse laws requiring professionals to report such cases. (The Tarasoff Case, suicide, and child abuse are reviewed in Chapter 8.)

In summary, the concept of confidentiality in professional relationships evolved over time. Initially it was generally regarded as absolute. However, in recent years, changes in legal and ethical thinking have moved professionals to believe confidentiality in the therapeutic relationship is limited. Confidentiality should be broken given the manifestations of certain criterion. The criterion for limited confidentiality is when the client presents a serious and imminent danger to the client or to others.

*Privileged communication* is the sister of confidentiality. While confidentiality is primarily the term associated with an ethical contextuality, privileged communication is primarily associated within a legal contextuality.

Privileged communication is a right granted by law to certain professionals not to testify in court regarding confidential information obtained in their professional relationship. Privileged communication originated in common law and has expanded over the years through legislative bodies. McDermott (1975) stated the reason for the existence of privileged communications.

> The nature of any particular physical or emotional anguish may be so intimate, suggestive or potentially injurious, that disclosure of the facts would subject the citizen to undue pain, loss of stature or injury to reputation. The citizen would be most reluctant to engage in helping relationships with the helping professionals if the intimacies of his private life were vulnerable to exposure on the entire public. (p. 25)

Privileged communication laws are strictly construed by the courts. Consequently, each practicum student and intern should be aware of what statutes exist in the state in which he/she is practicing. Care should be taken that the exact word of the law is taken. As an example, Virginia grants privileges to counselors, social workers, and psychologists in civil cases, not criminal cases. The law does not name school counselors or clerical workers who maintain school records (Hummel, Talbutt, & Alexander, 1985).

In contrast, Pennsylvania school counselors and school clerks are extended the privilege. The following is an example of Pennsylvania law regarding privileged communication:

> Act 287 (1972)
>
> Amending the act of March 10, 1949 (P.L. 30), entitled "An act relating to the public school system, including certain provisions applicable as well to private and parochial schools; amending, revising, consolidating and changing the laws relating thereto," providing for confidentiality of student communications.
>
> The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:
>
> Section 1. The act of March 10, 1949," (P.L. 30), known as the "Public School Code of 1949," is amended by adding after section 1318, a new section to read:
>
> Section 1319. Confidentiality of Student Communications.—No guidance counselor, school nurse or school psychologist in the public schools or in private or parochial schools or other educational institutions providing elementary or secondary education, including any clerical worker of such schools and institutions, who, while in the course of his professional duties for a guidance counselor, school nurse or school psychologist, has acquired information from a student in confidence shall be compelled or allowed without the consent of the student, if the student is eighteen (18) years of age or over, or if the student is under the age of eighteen (18) years, without the consent of his or her parent or legal guardian, to disclose that information in any legal proceeding, civil or criminal, trial, investigation before any grand, traverse or petit jury, or any officer thereof, before the General Assembly or any committee thereof, or before any commission, department or bureau of this Commonwealth, or municipal body, officer of committee thereof. Notwithstanding the confidentiality provisions of this section, no such person shall be excused or prevented from complying with the act of August 14, 1967 (P.L. 239), entitled "An act relating to gross physical neglect of, or injury to, children under eighteen years of age; requiring reports in such cases by examining physicians or heads of institutions to county public child welfare agencies; imposing powers and duties on county public child welfare agencies based on such reports; and providing penalties." (p. 1335)

Given that the client has a right to privacy, then a valid procedure is to inform him/her if any limits exist to confidentiality that could possibly endanger that right. Some argue that to inform the clients of all the myriad right they have is a detriment to the therapeutic relationship, giving rise to fears that are non-existent. On the other hand, others believe that a client should be given every opportunity to reflect on whether or not he/she wants to waive any rights and that if the therapist shows sensitivity to this issue, it will nurture a trusting relationship. Today many therapists, although not all, routinely inform their clients that if they present a serious harm to themselves or others, confidentiality may have to be broken. Ideally this should be done before therapy starts.

Many writers think that a client should be informed of other variables that could possibly influence his/her consent. Some of the variables are as follows:

1. What counseling techniques are going to be used?
2. Why these techniques are more appropriate to a particular client's presenting symptoms?
3. What other techniques have been found useful and beneficial to similar clients?
4. How long will the counseling/therapy take place?
5. What risks are involved in the treatment?
6. What are the professional background, credentials, and experience of the counselor, psychologist?
7. What are the resulting benefits of the treatment?
8. After the treatment has started, may questions be asked about the procedures being used?
9. When and with whom can the client review his/her records?
10. Can the client withdraw from the treatment at any time?
11. Will the sessions be supervised and by whom?
12. What electronic systems such as audio or video tapes will be used?
13. Who will view the tapes?
14. How long will the tapes be kept?
15. Has the therapist been granted privileged communication?

Practicum students and interns should investigate their agencies' policy regarding confidentiality and informed consent. They also should investigate the state law as it relates to privileged communication.

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* * *

# ETHICAL STANDARDS*

## American Association for Counseling and Development

(Approved by Executive Committee upon
referral of the Board of Directors,
January 17, 1981)

## PREAMBLE

*The Association is an educational, scientific, and professional organization whose members are dedicated to the enhancement of the worth, dignity, potential, and uniqueness of each individual and this to the service of society.*

*The Association recognizes that the role of definitions and work settings of its members include a wide variety of academic disciplines, levels of academic preparation and agency services. This diversity reflects the breadth of the Association's interest and influence. It also poses challenging complexities in efforts to set standards for the performance of members, desired requisite preparation or practice, and supporting social, legal, and ethical control.*

*The specification of ethical standards enables the Association to clarify to present and future members and to those served by members, the nature of ethical responsibilities held in common by its members.*

*The existence of such standards serves to stimulate greater concern by members for their own professional functioning and for the conduct of fellow professionals such as counselors, guidance and student personal workers, and others in the helping professions. As the ethical code of the Association, this document establishes principles that define the ethical behavior of Association members.*

## SECTION A:
## GENERAL

1. The member influences the development of the profession by continuous efforts to improve professional practices, teaching, services, and research. Professional growth is continuous throughout the member's career and is exemplified by the development of a philosophy that explains why and how a member functions in the helping relationship. Members must gather data on their effectiveness and be guided by the findings.

2. The member has a responsibility both to the individual who is served and to the institution within which the service is performed to maintain high standards of professional conduct. The member strives to maintain the highest levels of professional services offered to the individuals to be served. The

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member also strives to assist the agency, organization, or institution in providing the highest caliber of professional services. The acceptance of employment in an institution implies that the member is in agreement with the general policies and principles of the institution. Therefore the professional activities of the member are also in accord with the objectives of the institution. If, despite concerted efforts, the member cannot reach agreement with the employer as to acceptable standards of conduct that allow for changes in institutional policy conducive to the positive growth and development of clients, then terminating the affiliation should be seriously considered.

3. Ethical behavior among professional associates, both members and nonmembers, must be expected at all times. When information is possessed that raises doubt as to the ethical behavior of professional colleagues, whether Association members or not, the member must take action to attempt to rectify such a condition. Such action shall use the institution's channels first and then use procedures established by the state Branch, Division, or Association.

4. The member neither claims nor implies professional qualifications exceeding those possessed and is responsible for correcting any misrepresentations of these qualifications by others.

5. In establishing fees for professional counseling services, members must consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, assistance must be provided in finding comparable services of acceptable cost.

6. When members provide information to the public or to subordinates, peers or supervisors, they have a responsibility to ensure that the content is general, unidentified client information that is accurate, unbiased, and consists of objective, factual data.

7. With regard to the delivery of professional services, members should accept only those positions for which they are professional qualified.

8. In the counseling relationship the counselor is aware of the intimacy of the relationship and maintains respect for the client and avoids engaging in activities that seek to meet the counselor's personal needs at the expense of that client. Through awareness of the negative impact of both racial and sexual stereotyping and discrimination, the counselor guards the individual rights and personal dignity of the client in the counseling relationship.

## SECTION B: COUNSELING RELATIONSHIP

This section refers to practices and procedures of individual and/or group counseling relationships.

The member must recognize the need for client freedom of choice. Under those circumstances whether this is not possible, the member must apprise clients of restrictions that may limit their freedom of choice.

1. The member's *primary* obligation is to respect the integrity and promote welfare of the client(s), whether the client(s) is (are) assisted individually or in a group relationship. In a group setting, the member is also responsible for taking reasonable precautions to protect individuals from physical and/or psychological trauma resulting from interaction within the group.

2. The counseling relationship and information resulting therefrom be kept confidential, consistent with the obligations of the member as a professional person. In a group counseling setting, the counselor must set a norm of confidentiality regarding all group participants' disclosures.

3. If an individual is already in a counseling relationship with another professional person, the member does not enter into a counseling relationship without first contacting and receiving the approval of that other professional. If the member discovers that the client is in another counseling relationship after the counseling relationship begins, the member must gain the consent of the other professional or terminate the relationship, unless the client elects to terminate the other relationship.

4. When the client's condition indicates that there is clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities. Consultation with other professionals must be used where possible. The assumption of responsibility for the client(s) behavior must be taken only after careful deliberation. The client must be involved in the resumption of responsibility as quickly as possible.

5. Records of the counseling relationship, including interview notes, test data, correspondence, tape recordings, and other documents, are to be considered professional information for use in counseling and they should not be considered a part of the records of the institution or agency in which the counselor is employed unless specified by state statute or regulation. Revelation to others of counseling material must occur only upon the expressed consent of the client.

6. Use of data derived from a counseling relationship for purposes of counselor training or research shall be confined to content that can be disguised to ensure full protection of the identity of the subject client.

7. The member must inform the client of the purposes, goals, techniques, rules of procedure and limitations that may affect the relationship at or before the time that the counseling relationship is entered.

8. The member must screen prospective group participants, especially when the emphasis is on self-understanding and growth through self-disclosure. The member must maintain an awareness of the group participants' compatibility throughout the life of the group.

9. The member may choose to consult with any other professionally competent person about a client. In choosing a consultant, the member must avoid placing the consultation in a conflict of interest situation that would preclude the consultant's being a proper party to the member's efforts to help the client.

10. If the member determines an inability to be of professional assistance to the client, the member must either avoid initiating the counseling relationship or immediately terminate that relationship. In either event, the member must suggest appropriate alternatives. (The member must be knowledgeable about referral resources so that a satisfactory referral resources so that a satisfactory referral can be initiated.) In the event the client declines the suggested referral, the member is not obligated to continue the relationship.

11. When the member has other relationships, particularly of an administrative, supervisory and/or evaluative nature with an individual seeking counseling services, the member must not serve as the counselor but should refer the individual to another professional. Only in instances where such an alternative is unavailable and where the individual's situation warrants counseling intervention should the member enter into and/or maintain a counseling relationship. Dual relationships with clients that might impair the member's objectivity and professional judgment (e.g., as with close friends or relatives, sexual intimacies with any client) must be avoided and/or the counseling relationship terminated through referral to another competent professional.

12. All experimental methods of treatment must be clearly indicated to prospective recipients and safety precautions are to be adhered to by the member.

13. When the member is engaged in short-term group treatment/training programs (e.g., marathons and other encounter-type growth groups), the member ensures that there is professional assistance available during and following the group experience.

14. Should the member be engaged in a work setting that calls for any variation from the above statements, the member is obligated to consult with other professionals whenever possible to consider justifiable alternatives.

## SECTION C: MEASUREMENT AND EVALUATION

The primary purpose of educational and psychological testing is to provide descriptive measures that are objective and interpretable in either comparative or absolute terms. The member must recognize the need to interpret the statements that follow as applying to the whole range of appraisal techniques including test and nontest data. Test results constitute only one of a variety of pertinent sources of information for personnel, guidance, and counseling decisions.

1. The member must provide specific orientation or information to the examinee(s) prior to and following the test administration so that the results of testing may be placed in proper perspective with other relevant factors. In so doing, the member must recognize the effects of socioeconomic, ethnic and cultural factors on test scores. It is the member's professional responsibility to use additional unvalidated information carefully in modifying interpretation of the test results.

2. In selecting tests for use in a given situation or with a particular client, the member must consider carefully the specific validity, reliability, and appropriateness of the test(s). *General* validity, reliability and the like may be questioned legally as well as ethically when tests are used for vocational and educational selection, placement, or counseling.

3. When making any statements to the public about tests and testing, the member must give accurate information and avoid false claims or misconceptions. Special efforts are often required to avoid unwarranted connotations of such terms as *IQ* and *grade equivalent scores.*

4. Different tests demand different levels of competence for administration, scoring, and interpretation. Members must recognize the limits of their competence and perform only those functions for which they are prepared.

5. Tests must be administered under the same conditions that were established in their standardization. When tests are not administered under standard conditions or when unusual behavior or irregularities occur during the testing session, those conditions must be noted and the results designated as invalid or of questionable validity. Unsupervised or inadequately supervised test-taking, such as the use of tests through the mails, is considered unethical. On the other hand, the use of instruments that are so designed or standardized to be self-administered and self-scored, such as interest inventories, is to be encouraged.

6. The meaningfulness of test results used in personnel, guidance, and counseling functions generally depends on the examinee's unfamiliarity with the specific items on the test. Any prior coaching or dissemination of the test materials can invalidate test results. Therefore, test security is one of the professional obligations of the member. Conditions that produce most favorable test results must be make known to the examinee.

7. The purpose of testing and the explicit use of the results must be made known to the examinee prior to testing. The counselor must ensure that instrument limitations are not exceeded and that periodic review and/or retesting are made to prevent client stereotyping.

8. The examinee's welfare and explicit prior understanding must be the criteria for determining the recipients of the test results. The member must see that specific interpretation accompanies any release of individual or group test data. The interpretation of test data must be related to the examinee's particular concerns.

9. The member must be cautious when interpreting the results of research instruments possessing insufficient technical data. The specific purposes for use of such instruments must be stated explicitly to examinees.

10. The member must proceed with caution when attempting to evaluate and interpret the performance of minority group members or other persons who are not represented in the norm group on which the instrument was standardized.

11. The member must guard against the appropriation, reproduction, or modification of published tests or parts thereof without acknowledgement and permission from the previous publisher.

12. Regarding the preparation, publication and distribution of tests, reference should be made to:

    a. *Standards for Educational and Psychological Tests and Manuals*, revised edition, 1974, published by the American Psychological Association on behalf of itself, the American Educational Research Association and the National Council on Measurement in Education.

    b. The responsible use of tests: A position paper of AMEG, APGA, and NCME. *Measurement and Evaluation in Guidance*, 1972, 5, 385-388.

    c. "Responsibilities of Users of Standardized Tests," APGA, Guidepost, October 5, 1978, pp. 5-8.

## SECTION D: RESEARCH AND PUBLICATION

1. Guidelines on research with human subjects shall be adhered to, such as:

    a. *Ethical Principles in the Conduct of Research with Human Participants*, Washington, DC: American Psychological Association, Inc. 1973.

    b. Code of Federal Regulations, Title 45, Subtitle A, Part 46, as currently issued.

2. In planning any research activity dealing with human subjects, the member must be aware of and responsive to all pertinent ethical principles and ensure that the research problem, design, and execution are in full compliance with them.

3. Responsibility for ethical research practice lies with the principal researcher, while others involved in the research activities share ethical obligation and full responsibility for their own actions.

4. In research with human subjects, researchers are responsible for the subjects' welfare throughout the experiment and they must take all reasonable precautions to avoid causing injurious psychological, physical, or social effects on their subjects.

5. All research subjects must be informed of the purpose of the study except when withholding information or providing misinformation to them is essential to the investigation. In such research the member must be responsible for corrective action as soon as possible following completion of the research.

6. Participation in research must be voluntary. Involuntary participation is appropriate only when it can be demonstrated that participation will have no harmful effects on subjects and is essential to the investigation.

7. When reporting research results, explicit mention must be made of all variables and conditions known to the investigator that might affect the outcome of the investigation or the interpretation of the data.

8. The member must be responsible for conducting and reporting investigations in a manner that minimizes the possibility that results will be misleading.

9. The member has an obligation to make available sufficient original research data to qualified others who may wish to replicate the study.

10. When supplying data, aiding in the research of another person, reporting research results, or in making original data available, due care must be taken to disguise the identity of the subjects in the absence of specific authorization from such subjects to do otherwise.

11. When conducting and reporting research, the member must be familiar with, and give recognition to, previous work on the topic, as well as to observe all copyright laws and follow the principles of giving full credit to all to whom credit is due.

12. The member must give due credit through joint authorship, acknowledgement, footnote statements, or other appropriate means to those who have contributed significantly to the research and/or publication, in accordance with such contributions.

13. The member must communicate to other members the results of any research judged to be of professional or scientific value. Results reflecting unfavorably on institutions, programs, services, or vested interests must not be withheld for such reasons.

14. If members agree to cooperate with another individual in research and/or publication, they incur an obligation to cooperate as promised in terms of punctuality of performance and with full regard to the completeness and accuracy of the information required.

15. Ethical practice requires that authors not submit the same manuscript or one essentially similar in content, for simultaneous publication consideration by two or more journals. In addition, manuscripts published in whole or in substantial part, in another journal or published work should not be submitted for publication without acknowledgement and permission from the previous publication.

## SECTION E: CONSULTING

*Consultation* refers to a voluntary relationship between a professional helper and help-needing individual, group or social unit in which the consultant is providing help to the client(s) in defining and solving a work-related problem or potential problem with a client or client system. [This definition is adapted from Kurpius, DeWayne.

Consultation theory and process: *An integrated model. Personnel and Guidance Journal*, 1978, 56.]

1. The member acting as consultant must have a high degree of self-awareness of his-her own values, knowledge, skills, limitations, and needs in entering a helping relationship that involves human and-or organizational change and that the focus of the relationship be on the issues to be resolved and not on other person(s) presenting the problem.

2. There must be understanding and agreement between member and client for the problem definition, change goals, and predicated consequences of interventions selected.

3. The member must be reasonably certain that he/she or the organization represented has the necessary competencies and resources for giving the kind of help that is needed now or may develop later and that appropriate referral resources are available to the consultant.

4. The consulting relationship must be one in which client adaptability and growth toward self-direction are encouraged and cultivated. The member must maintain this role consistently and not become a decision maker for the client or create a future dependency on the consultant.

5. When announcing consultant availability for services, the member conscientiously adheres to the Association's *Ethical Standards*.

6. The member must refuse a private fee or other remuneration for consultation with persons who are entitled to these services through the member's employing institution or agency. The policies of a particular agency may make explicit provisions for private practice with agency clients by members of its staff. In such instances, the clients must be apprised of other options open to them should they seek private counseling services.

## SECTION F:
## PRIVATE PRACTICE

1. The member should assist the profession by facilitating the availability of counseling services in private as well as public settings.

2. In advertising services as a private practitioner, the member must advertise the services in such a manner so as to accurately inform the public as to services, expertise, profession, and techniques of counseling in a professional manner. A member who assumes an executive leadership role in the organization shall not permit his/her name to be used in professional notices during the periods when not actively engaged in the private practice of counseling.

   The member may list the following: highest relevant degree, type and level of certification or license, type and/or description of services, and other relevant information. Such information must not contain false, inaccurate, misleading, partial, out-of-context, or deceptive material or statements.

3. Members may join in partnership/corporation with other members and-or other professionals provided that each member of the partnership or corporation makes clear the separate specialties by name in compliance with the regulations of the locality.

4. A member has an obligation to withdraw from a counseling relationship if it is believed that employment will result in violation of the *Ethical Standards*. If the mental or physical condition of the member renders it difficult to carry out an effective professional relationship or if the member is discharged by the client because the counseling relationship is no longer productive for the client, then the member is obligated to terminate the counseling relationship.

5. A member must adhere to the regulations for private practice of the locality where the services are offered.

6. It is unethical to use one's institutional affiliation to recruit clients for one's private practice.

## SECTION G:
## PERSONNEL ADMINISTRATION

It is recognized that most members are employed in public or quasi-public institutions. The functioning of a member within an institution must contribute to the goals of the institution and vice versa if either is to accomplish their respective goals or objectives. It is therefore essential that the member and the institution function in ways to (a) make the institution's goals explicit and public; (b) make the member's contribution to institutional goals specific; and (c) foster mutual accountability for goal achievement.

To accomplish these objectives, it is recognized that the member and the employer must share responsibilities in the formulation and implementation of personnel policies.

1. Members must define and describe the parameters and levels of their professional competency.

2. Members must establish interpersonal relations and working agreements with supervisors and subordinates regarding counseling or clinical relationships, confidentiality, distinction between public and private material, maintenance, and dissemination of recorded information, work load and accountability. Working agreements in each instance must be specified and made known to those specified and made known to those concerned.

3. Members must alert their employers to conditions that may be potentially disruptive or damaging.

4. Members must inform employers of conditions that may limit their effectiveness.

5. Members must submit regularly to professional review and evaluation.

6. Members must be responsible for inservice development of self and-or staff.

7. Members must inform their staff of goals and programs.

8. Members must provide personnel practices that guarantee and enhance the rights and welfare of each recipient of their service.

9. Members must select competent persons and assign responsibilities compatible with their skills and experiences.

## SECTION H: PREPARATION STANDARDS

Members who are responsible for training others must be guided by the preparation standards of the Association and relevant Division(s). The member who functions in the capacity of trainer assumes unique ethical responsibilities that frequently go beyond that of the member who does not function in a training capacity. These ethical responsibilities are outlined as follows:

1. Members must orient students to program expectations, basic skills development, and employment prospects prior to admission to the program.

2. Members in charge of learning experiences must establish programs that integrate academic study and supervised practice.

3. Members must establish a program directed toward developing students' skills, knowledge, and self-understanding, stated whenever possible in competency or performance terms.

4. Members must identify the levels of competencies of their students in compliance with relevant Division standards. These competencies must accommodate the para-professional as well as the professional.

5. Members, through continual student evaluation and appraisal, must be aware of the personal limitations of the learner that might impede future performance. The instructor must not only assist the learner in securing remedial assistance but also screen from the program those individuals who are unable to provide competent services.

6. Members must provide a program that includes training in research commensurate with levels of role functioning. Para-professional and technician-level personnel must be trained as consumers of research. In addition, these personnel must learn how to evaluate their own and their program's effectiveness. Graduate training, especially at the doctoral level, would include preparation for original research by the member.

7. Members must make students aware of the ethical responsibilities and standards of the profession.

8. Preparatory programs must encourage students to value the ideals of service to individuals and to society. In this regard, direct financial remuneration or lack of must not influence the quality of service rendered. Monetary considerations must not be allowed to overshadow professional and humanitarian needs.

9. Members responsible for educational programs must be skilled as teachers and practitioners.

10. Members must present thoroughly varied theoretical positions so that students may make comparisons and have the opportunity to select a position.

11. Members must develop clear policies within their educational institutions regarding field placement and the roles of the student and the instructor in such placements.

12. Members must ensure that forms of learning focusing on self-understanding or growth are voluntary, or if required as part of the education program, are made known to prospective students prior to entering the program. When the education program offers a growth experience with an emphasis on self-disclosure or other relatively intimate or personal involvement, the member must have the administrative, supervisory, or evaluating authority regarding the participant.

13. Members must conduct an educational program in keeping with the current relevant guidelines of the Association and its Divisions.

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# ETHICAL PRINCIPLES OF PSYCHOLOGISTS*

(1981 Revision)

## PREAMBLE

Psychologists respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights. They are committed to increasing knowledge of human behavior and of people's understanding of themselves and others and to utilization of such knowledge for the promotion of human welfare. While pursuing these objectives, they make every effort to protect the welfare of those who seek their services and of the research participants that may be the object of study. They use their skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding for themselves freedom of inquiry and communication, psychologists accept the responsibility this freedom requires: competence, objectivity in the application of skills, and concern for the best interests of clients, colleagues, students, research participants and society. In the pursuit of these ideals, psychologists subscribe to principles in the following areas: 1. Responsibility

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2. Competence, 3. Moral and Legal Standards, 4. Public Statements, 5. Confidentiality, 6. Welfare of the Consumer, 7. Professional Relationships, 8. Assessment Techniques, 9. Research with Human Participants, and 10. Care and Use of Animals.

Acceptance of membership in the American Psychological Association commits the member to adherence to these principles.

Psychologists cooperate with duly constituted committees of the American Psychological Association, in particular, the Committee on Scientific and Professional Ethics and Conduct, by responding to inquiries promptly and completely. Members also respond promptly and completely to inquiries from duly constituted state association ethics committees and professional standards review committees.

## PRINCIPLE 1 RESPONSIBILITY

In providing services, psychologists maintain the highest standards of their profession. They accept responsibility for the consequences of their acts and make every effort to insure that their services are used appropriately.

a. As scientists, psychologists accept responsibility for the selection of their research topics and the methods used in investigation, analysis, and reporting. They plan their research in ways to minimize the possibility that their findings will be misleading. They provide thorough discussion of the limitations of their data, especially where their work touches on social policy or might be construed to the detriment of persons in specific age, sex, ethnic, socioeconomic or other social groups. In publishing reports of their work, they never suppress disconfirming data, and they acknowledge the existence of alternative hypotheses and explanations of their findings. Psychologists take credit only for work they have actually done.

b. Psychologists clarify in advance with all appropriate persons and agencies the expectations for sharing and utilizing research data. They avoid relationships which may limit their objectivity or create a conflict of interest. Interference with the milieu in which the data are collected is kept to a minimum.

c. Psychologists have the responsibility to attempt to prevent distortion, misuse, or suppression of psychological findings by the institution or agency of which they are employees.

d. As members of governmental or other organizational bodies, psychologists remain accountable as individuals to the highest standards of their profession.

e. As teachers, psychologists recognize their primary obligation to help others acquire knowledge and skill. They maintain high standards of scholarship by presenting psychological information objectively, fully and accurately.

f. As practitioners, psychologists know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They are alert to personal, social, organizational, financial, or political situations and pressures that might lead to misuse of their influence.

## PRINCIPLE 2 COMPETENCE

The maintenance of high standards of competence is a responsibility shared by all psychologists in the interest of the public and the profession as a whole. Psychologists recognize the boundaries of their competence and the limitations of their techniques. They only provide services and only use techniques for which they are qualified by training and experience. In those areas in which recognized standards do not yet exist, psychologists take whatever precautions are necessary to protect the welfare of their clients. They maintain knowledge of current scientific and professional information related to the services they render.

a. Psychologists accurately represent their competence, education, training, and experience. They claim as evidence of educational qualifications only those degrees obtained from institutions acceptable under the Bylaws and Rules of Council of the American Psychological Association.

b. As teachers, psychologists perform their duties on the basis of careful presentation so that their instruction is accurate, current, and scholarly.

c. Psychologists recognize the need for continuing education and are open to new procedures and changes in expectations and values over time.

d. Psychologists recognize differences among people, such as those that may be associated with age, sex, socioeconomic, and ethnic backgrounds. When necessary, they obtain training, experience, or counsel to assure competent service or research relating to such persons.

e. Psychologists responsible for decisions involving individuals or policies based on test results have an understanding of psychological or educational measurement, validation problems, and test research.

f. Psychologists recognize that personal problems and conflicts may interfere with professional effectiveness. Accordingly, they refrain from undertaking any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student, or research participant. If engaged in such activity when they become aware of their personal problems, they seek competent professional assistance to determine whether they should suspend, terminate, or limit the scope of their professional and/or scientific activities.

## PRINCIPLE 3 MORAL AND LEGAL STANDARDS

Psychologists' moral and ethical standards of behavior are a personal matter to the same degree as they are for any other citizen, except as these may compromise the fulfillment of their professional responsibilities, or reduce the public trust in psychology and psychologists. Regarding their own behavior, psychologists are sensitive to prevailing community standards and to the possible impact that conformity to or deviation from these standards may have upon the quality of their performance as psychologists. Psychologists are also aware of the possible impact of their public behavior upon the ability of colleagues to perform their professional duties.

a. As teachers, psychologists are aware of the fact that their personal values may affect the selection and presentation of instructional materials. When dealing with topics that may give offense, they recognize and respect the diverse attitudes that students may have toward such materials.

b. As employees or employers, psychologists do not engage in or condone practices that are inhumane or that result in illegal or unjustifiable actions. Such practices include but are not limited to those based on considerations of race, handicap, age, gender, sexual preference, religion, or national origin in hiring, promotion, or training.

c. In their professional roles, psychologists avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by their actions.

d. As practitioners and researchers, psychologists act in accord with Association standards and guidelines related to the practice and to the conduct of research with human beings and animals. In the ordinary course of events psychologists adhere to relevant governmental laws and institutional regulations. When federal, state, provincial, organizational, or institutional laws, regulations, or practices are in conflict with Association standards and guidelines, psychologists make known their commitment to Association standards and guidelines, and wherever possible work toward a resolution of the conflict. Both practitioners and researchers are concerned with the development of such legal and quasi-legal regulations as best serve the public interest, and they work toward changing existing regulations that are not beneficial to the public interest.

## PRINCIPLE 4 PUBLIC STATEMENTS

Public statements, announcements of services, advertising, and promotional activities of psychologists serve the purpose of helping the public make informed judgements and choices. Psychologists represent accurately and objectively their professional qualifications, affiliations, and functions, as well as those of the institutions or organizations with which they or the statements may be associated. In public statements providing psychological information or professional opinions or providing information about the availability of psychological products, publications, and services, psychologists base their statements on scientifically acceptable psychological findings and techniques with full recognition of the limits and uncertainties of such evidence.

a. When announcing or advertising professional services, psychologists may list the following information to describe the provider and services provided: name, highest relevant academic degree earned from a regionally accredited institution, date, type and level of certification or licensure, diplomate status, APA membership status, address, telephone number, office hours, a brief listing of the type of psychological services offered, an appropriate presentation of fee information, foreign languages spoken, and policy with regard to third-party payments. Additional relevant or important consumer information may be included if not prohibited by other sections of these Ethical Principles.

b. In announcing or advertising the availability of psychological products, publications, or services, psychologists do not present their affiliation with any organization in a manner that falsely implies sponsorship or certification by that organization. In particular and for example, psychologists do not state APA membership or fellow status in a way to suggest that such status implies specialized professional competence or qualifications. Public statements include, but are not limited to, communication by means of periodical, book, list, directory, television, radio, or motion picture. They do not contain: (i) a false, fraudulent, misleading, deceptive, or unfair statement; (ii) a misinterpretation of fact, or a statement likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts; (iii) a testimonial from a patient regarding the quality of a psychologist's services or products; (iv) a statement intended or likely to create false or unjustified expectations of favorable results; (v) a statement implying unusual, unique, or one-of-a-kind abilities; (vi) a statement intended or likely to appeal to a client's fears, anxieties, or emotions concerning the possible results of a failure to obtain the offered services; (vii) a statement concerning the comparative desirability of offered service; (viii) a statement of direct solicitation of individual clients.

c. Psychologists do not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of or in return for professional publicity in a news item. A paid advertisement must be identified as such, unless it is apparent from the context that it is a paid advertisement. If communicated to the public by use of radio or television, an advertisement shall be prerecorded and approved for broadcast by the psychologist, and a recording of the actual transmission shall be retained by the psychologist.

d. Announcements or advertisements of "personal growth groups," clinics and agencies give a clear statement of purpose and a clear description of the experience to be provided. The education, training, and experience of the staff members are appropriately specified.

e. Psychologists associated with the development or promotion of psychological devices, books, or other products offered for commercial sale make reasonable efforts to insure that announcements and advertisements are presented in a professional, scientifically acceptable, and factually informative manner.

f. Psychologists do not participate for personal gain in commercial announcements or advertisements recommending to the public the purchase or use of proprietary or single-source products or services when that participation is based solely upon their identification as psychologists.

g. Psychologists present the science of psychology and offer their services, products, and publications fairly and accurately, avoiding misrepresentation through sensationalism, exaggeration, or superficiality. Psychologists are guided by the primary obligation to aid the public in developing informed judgments, opinions, and choices.

h. As teachers, psychologists insure that statements in catalogs and course outlines are accurate and not misleading, particularly in terms of subject matter to be covered, bases for evaluating progress, and the nature of course experiences. Announcements, brochures, or advertisements describing workshops, seminars, or other educational programs accurately describe the audience for which the program is intended as well as eligibility requirements, educational objectives, and nature of the materials to be covered. These announcements also accurately represent the education, training, and experience of the psychologists presenting the programs, and any fees involved.

i. Public announcements or advertisements soliciting research participants in which clinical services or other professional services are offered as an inducement, make clear the nature of the services as well as the costs and the obligations to be accepted by the participants of the research.

j. Psychologists accept the obligation to correct others who represent that psychologist's professional qualifications, or associations with products or services, in a manner incompatible with these guidelines.

k. Individual diagnostic and therapeutic services are provided only in the context of a professional psychological relationship. When personal advice is given by means of public lecture or demonstration, newspaper or magazine articles, radio or television programs, mail, or similar media, the psychologist utilizes the most current relevant date and exercises the highest level of professional judgment.

l. Products that are described or presented by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, or similar media meet the same recognized standards as exist for use in the context of a professional relationship.

## PRINCIPLE 5
## CONFIDENTIALITY

Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.

a. Information obtained in clinical or consulting relationships, or evaluative data concerning children, student, employees, and others, are discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports present only data germane to the purposes of the evaluation and every effort is made to avoid undue invasion of privacy.

b. Psychologists who present personal information obtained during the course of professional work in writings, lectures, or other public forums either obtain adequate prior consent to do so or adequately disguise all identifying information.

c. Psychologists make provisions for maintaining confidentiality in the storage and disposal of records.

d. When working with minors or other persons who are unable to give voluntary, informed consent, psychologists take special care to protect these persons' best interests.

## PRINCIPLE 6
## WELFARE OF THE CONSUMER

Psychologists respect the integrity and protect the welfare of the people and groups with whom they work. When there is a conflict of interest between a client and the psychologist's employing institution, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom on choice with regard to participation.

a. Psychologists are continually cognizant of their own needs and of their potentially influential position vis-a-vis persons such as clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons. Psychologists make every effort to avoid dual relationships which could impair their professional judgment or increase the risk of exploitation. Examples of such dual relationships include but are not limited to research with and treatment of employees, students, supervisees, close friends, or relatives. Sexual intimacies with clients are unethical.

b. When a psychologist agrees to provide services to a client at the request of a third party, the psychologist assumes the responsibility of clarifying the nature of the relationships all parties concerned.

c. Where the demands of an organization require psychologists to violate these Ethical Principles, psychologists clarify the nature of the conflict between the demand and these principles. They inform all parties of psychologists' ethical responsibilities and take appropriate action.

d. Psychologists make advance financial arrangements that safeguard the best interests of and are clearly understood by their clients. They neither give nor receive any remuneration for referring clients for professional services. They contribute a portion of their services to work for which they receive little or no financial return.

e. Psychologists terminate a clinical or consulting relationship when it is reasonably clear the consumer is not benefiting from it. They offer to help the consumer locate alternative sources of assistance.

## PRINCIPLE 7
## PROFESSIONAL RELATIONSHIPS

Psychologists act with due regard for the needs, special competencies, and obligations of their colleagues in psychology and other professions. They respect the prerogatives and obligations of the institutions or organizations with which these other colleagues are associated

a. Psychologists understand the areas of competence of related professions. They make full use of all the professional, technical, and administrative resources that serve the best interests of consumers. The absence of formal relationships with other professional workers does not relieve psychologists of the responsibility of securing for their clients the best possible professional service nor does it relieve them of the obligation to exercise foresight, diligence, and tact in obtaining the complementary or alternative assistance needed by clients.

b. Psychologists know and take into account the traditions and practices of other professional groups with whom they work and cooperate fully with such groups. If a person is receiving similar services from another professional, psychologists do not offer their own services directly to such a person. If a psychologist is contacted by a person who is already receiving similar services from another professional, the psychologist carefully considers that professional relationship and proceeds with caution and sensitivity to the therapeutic issues as well as the client's welfare. The psychologist discusses these issues with the client so as to minimize the risk of confusion and conflict.

c. Psychologists who employ or supervise other professionals or professionals in training accept the obligation to facilitate the further professional development of these individuals. They provide appropriate working conditions, timely evaluations, constructive consultation and experience opportunities.

d. Psychologists do not exploit their professional relationships with clients, supervisees, students, employees or research participants sexually or otherwise. Psychologists do not condone nor engage in sexual harrassment. Sexual harrassment is defined as deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are unwanted by the recipient.

e. In conducting research in institutions or organizations, psychologists secure appropriate authorization to conduct such research. They are aware of their obligation to future research workers and insure that host institutions receive adequate information about the research and proper acknowledgement of their contribution.

f. Publication credit is assigned to those who have contributed to a publication in proportion to their professional contribution. Major contributions of a professional character made by several persons to a common project are recognized by joint authorship, with the individual who made the principal contribution listed first. Minor contributions of a professional character and extensive clerical or similar nonprofessional assistance may be acknowledged in footnotes or in an introductory statement. Acknowledgement through specific citations is made for unpublished as well as published material that has directly influenced the research or writing. A psychologist who compiles and edits material of others for publications publishes the material in the name of the originating group, if appropriate, with his/her own name appearing as chairperson or editor. All contributors are to be acknowledged and named.

g. When psychologists know of an ethical violation by another psychologist, and it seems appropriate, they informally attempt to resolve the issue by bringing the behavior to the attention of the psychologist. If the misconduct is of a minor nature and/or appears to be due to lack of sensitivity, knowledge, or experience, such an informal solution is usually appropriate. Such informal corrective efforts are sensitive to any rights to confidentially involved. If the violation does not seem amenable to an informal solution, or is of a more serious nature, psychologists bring it to the attention of the appropriate local, state, and/or national committee on professional ethics and conduct.

## PRINCIPLE 8
## ASSESSMENT TECHNIQUES

In the development, publication, and utilization of psychological assessment techniques, psychologists make every effort to promote the welfare and best interests of the client. They guard against the misuse of assessment results. They respect the client's right to know the results, the interpretations made and the bases for their conclusions and recommendations. Psychologists make every effort to maintain the security of tests and other assessment techniques within limits of legal mandates. They strive to assure the appropriate use of assessment techniques by others.

a. In using assessment techniques, psychologists respect the right of clients to have a full explanation of the nature and purpose of the techniques in language that the client can understand, unless an explicit exception to this right has been agreed upon in advance. When the explanations are to be provided by others, the psychologist establishes procedures for insuring the adequacy of these explanations.

b. Psychologists responsible for the development and standardization of psychological tests and other assessment techniques utilize established scientific procedures and observe the relevant APA standards.

c. In reporting assessment results, psychologists indicate any reservations that exist regarding validity or reliability because of the circumstances of the assessment or the inappropriateness of the norms for the person tested. Psychologists strive to insure that the results of assessments and their interpretations are not misused by others.

d. Psychologists recognize that assessment results may become obsolete. They make every effort to avoid and prevent the misuse of obsolete measures.

e. Psychologists offering scoring and interpretation services are able to produce appropriate evidence for the validity of the programs and procedures used in arriving at interpretations. The public offering of an automated interpretation service is considered as a professional-to-professional consultation. The psychologist makes every effort to avoid misuse of assessment reports.

f. Psychologists do not encourage or promote the use of psychological assessment techniques by inappropriately trained or otherwise unqualified persons through teaching sponsorship, or supervision.

## PRINCIPLE 9
## RESEARCH WITH HUMAN PARTICIPANTS

The decision to undertake research rests upon a considered judgment by the individual psychologist about how best to contribute to psychological science and human welfare. Having made the decision to conduct research, the psychologist considers alternative directions in which research energies and resources might be invested. On the basis of this consideration, the psychologist carries out the investigation with respect and concern for the dignity and welfare of the people who participate, and with cognizance of federal and state regulations and professional standards governing the conduct of research with human participants.

a. In planning a study, the investigator has the responsibility to make careful evaluation of its ethical acceptability. To the extent that the weighing of scientific and human values suggests a compromise of any principle, the investigator incurs a correspondingly serious obligation to see ethical advice and to observe stringent safeguards to protect the rights of human participants.

b. Considering whether a participant in a planned study will be a "subject at risk" or a "subject at minimal risk," according to recognized standards, is of primary ethical concern to the investigator.

c. The investigator always retains the responsibility for insuring ethical practice in research. The investigator is also responsible for the ethical treatment of research participants by collaborators, assistants, students, and employees, all of whom, however, incur similar obligations.

d. Except for minimal risk research, the investigator establishes a clear and fair agreement with the research participants, prior to their participation, that clarifies the obligations and responsibilities of each. The investigator has the obligation to honor all promises and commitments included in that agreement. The investigator informs the participant of all aspects of the research that might reasonably be expected to influence willingness to participate, and explains all other aspects of the research about which the participant inquires. Failure to make full disclosure prior to obtaining informed consent requires additional safeguards to protect the welfare and dignity of the research participant. Research with children or participants who have impairments which would limit understanding and/or communication, requires special safeguard procedures.

e. Methodological requirements of a study may make the use of concealment or deception necessary. Before conducting such a study, the investigator has a special responsibility to: (i) determine whether the use of such techniques is justified by the study's prospective, scientific, educational, or applied value; (ii) determine whether alternative procedures are available that do not utilize concealment or deception; and (iii) insure that the participants are provided with sufficient explanation as soon as possible.

f. The investigator respects the individual's freedom to decline to participate in or to withdraw from the research at any time. The obligation to protect this freedom requires careful thought and consideration when the investigator is in a position of authority or influence over the participant. Such positions of authority include but are not limited to situations when research participation is required as part of employment or when the participant is a student, client, or employee of the investigator.

g. The investigator protects the participants from physical and mental discomfort, harm, and danger that may arise from research procedures. If risks of such consequences exist, the investigator informs the participant of that fact. Research procedures likely to cause serious or lasting harm to a participant are not used unless the failure to use these procedures might expose the participant to risk of greater harm, or unless the research has great potential benefit and fully informed and voluntary consent is obtained from each participant. The participant should be informed of procedures for contacting the investigator within a reasonable time period following participation should stress, potential harm, or related questions or concerns arise.

h. After the data are collected, the investigator provides the participant with information about the nature of the study and attempts to remove any misconceptions that may have arisen. Where scientific or humane values justify delaying or withholding information, the investigator incurs a special responsibility to monitor the research and to assure that there are not damaging consequences for the participant.

i. Where research procedures result in undesirable consequences for the individual participant, the investigator has the responsibility to detect and remove or correct these consequences, including long-term effects.

j. Information obtained about the research participant during the courses of an investigation is confidential unless otherwise agreed upon in advance. When the possibility exists that others may obtain access to such information, this possibility, together with the plans for protecting confidentiality, is explained to the participant as part of the procedure for obtaining informed consent.

## PRINCIPLE 10
## CARE AND USE OF ANIMALS

An investigator of animal behavior strives to advance our understanding of basic behavioral principles and/or to contribute to the improvement of human health and welfare. In seeking these ends, the investigator insures the welfare of the animals and treats them humanely. Laws and regulations notwithstanding, the animal's immediate protection depends upon the scientist's own conscience.

a. The acquisition, care, use, and disposal of all animals is in compliance with current federal, state or provincial, and local laws and regulations.

b. A psychologist trained in research methods and experienced in the care of laboratory animals closely supervises all procedures involving animals and is responsible for insuring appropriate consideration of their comfort, health, and humane treatment.

c. Psychologists insure that all individuals using animals under their supervision have received explicit instruction in experimental methods and in the care, maintenance, and handling of the species being used. Responsibilities and activities of individuals participating in a research project are consistent with their respective competencies.

d. Psychologists make every effort to minimize discomfort, illness, and pain to the animals. A procedure subjecting animals to pain, stress, or privation is used only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value. Surgical procedures are performed under appropriate anesthesia; techniques to avoid infection and minimize pain are followed during and after surgery.

e. When it is appropriate that the animal's life be terminated, it is done rapidly and painlessly.

## NOTES

[1] Approved by the Council of Representatives (January 1981).

[2] These Ethical Principles apply to psychologists, to students of psychology and others who do work of a psychological nature under the supervision of a psychologist. They are also intended for the guidance of non-members of the Association who are engaged in psychological research or practice.

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# CODE OF ETHICS FOR CERTIFIED CLINICAL MENTAL HEALTH COUNSELORS, _NATIONAL ACADEMY OF CERTIFIED CLINICAL MENTAL HEALTH COUNSELORS_*

## PREAMBLE

Certified Clinical Mental Health Counselors believe in the dignity and worth of the individual. They are committed to increasing knowledge of human behavior and understanding of themselves and others. While pursuing the endeavors, they make every reasonable effort to protect the welfare of those who seek their services or of any subject that may be the object of study. They use their skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding for themselves freedom of inquiry and communication, certified clinical mental health counselors accept the responsibility this freedom confers: competence, objectivity in the application of skills and concern for the best interests of clients, colleagues, and society in general. In the pursuit of these ideals, clinical mental health counselors subscribe to the following principles:

## Principle 1: Responsibility

In their commitment to the understanding of human behavior, clinical mental health counselors value objectivity and integrity, and in providing services they maintain the highest standards. They accept responsibility for the consequences of their worth and make every effort to insure that their services are used appropriately.

a. Clinical mental health counselors accept ultimate responsibility for selecting appropriate areas for investigation and the methods relevant to minimize the possibility that their finding will be misleading. They provide thorough discussion of the limitations of their data and alternative hypotheses, especially whether their work touches on social policy or might be misconstrued to the detriment of specific age, sex, ethnic, socio-economic, or other social categories. In publishing reports of their work, they never discard observations that may modify the interpretation of results. Clinical mental health counselors take credit only for the work they have actually done. In pursuing research, clinical mental health counselors ascertain that their efforts will not lead to changes in individuals or organizations unless such changes are part of the agreement at the time of obtaining informed consent. Clinical mental health counselors clarify in advance the expectations for sharing and utilizing research data. They avoid dual relationships which may limit objectivity, whether theoretical, political, or monetary, so that interference with data, subjects, and milieu is kept to a minimum.

b. As employees at an institution or agency, clinical mental health counselors have the responsibility of remaining alert to institutional pressures which may distort reports of counseling findings or use them in ways counter to the promotion of human welfare.

c. When serving as members of governmental or other organizational bodies, clinical mental health counselor remain accountable as individuals to the Code of Ethics of the National Academy of Certified Mental Health Counselors.

d. As teachers, clinical mental health counselors recognize their primary obligation to help others acquire knowledge and skill. They maintain high standards of scholarship and objectivity by presenting counseling information fully and accurately, and by giving appropriate recognition to alternative viewpoints.

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e. As practitioners, clinical mental health counselors know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They therefore remain fully cognizant of their impact and alert to personal, social, organizational, financial or political situations or pressures which might lead to misuse of their influence.

f. Clinical mental health counselors provide reasonable and timely feedback to employees, trainees, supervisors, students and others whose work they may evaluate.

## Principle 2: Competence

The maintenance of high standards of professional competence is a responsibility shared by all clinical mental health counselors in the interest of the public and the profession as a whole. Clinical mental health counselors recognize the boundaries of their competence and the limitations of their techniques and only provide services, use techniques, or offer opinions as professionals that meet recognized standards. Throughout their careers, clinical mental health counselors maintain knowledge of professional information related to the services they render.

a. Clinical mental health counselors accurately represent their competence, education, training and experience.

b. As teachers, clinical mental health counselors perform their duties based on careful preparation so that their instruction is accurate, up-to-date and scholarly.

c. Clinical mental health counselors recognize the need for continuing training to prepare themselves to serve persons of all ages and cultural backgrounds. They are open to new procedures and sensitive to differences between groups of people and changes in expectations and values over time.

d. Clinical mental health counselors with the responsibility for decisions involving individuals or policies based on test results should know and understand literature relevant to the tests used and testing problems with which they deal.

e. Clinical mental health counselors/practitioners recognize that their effectiveness depends in part upon their ability to maintain sound interpersonal relations, the temporary or more enduring aberrations on their part may interfere with their abilities or distort their appraisals of others. Therefore, they refrain from undertaking any activity or harm to a client, or, if they are already engaged in such activity when they become aware of their personal problems, they would seek competent professional assistance to determine whether they should suspend or terminate services to one or all of their clients.

## Principle 3: Moral and legal standards

Clinical mental health counselors' moral, ethical, and legal standards of behavior are a personal matter to the same degree as they are for any other citizen, except as these may compromise the fulfillment of their professional responsibilities, or reduce the trust in counseling or counselors held by the general public. Regarding their own behavior, clinical mental health counselors should be aware of the prevailing community standards and of the possible impact upon the quality of professional services provided by their conformance to or deviation from these standards. Clinical mental health counselors should also be aware of the possible impact of their public behavior upon the ability of colleagues to perform their professional duties.

a. To protect public confidence in the profession of counseling, clinical mental health counselors will avoid public behavior that is clearly in violation of accepted moral and legal standards.

b. To protect students, counselors/teachers will be aware of the diverse backgrounds of students and, when dealing with topics that may give offense, will see that the material is treated objectively, that it is clearly relevant to the course, and that it is treated in a manner for which the student is prepared.

c. Providers of counseling services conform to the statutes relating to such services as established by their state and its regulating professional board(s).

d. As employees, clinical mental health counselors refuse to participate in employer's practices which are inconsistent with the moral and legal standards established by federal or state legislation regarding the treatment of employees or of the public. In particular and for example, clinical mental health counselors will not condone practices which result in illegal or otherwise unjustifiable discrimination on the basis of race, sex, religion or national origin in hiring, promotion or training.

e. In providing counseling services to clients clinical mental health counselors avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by the action.

f. Sexual conduct, not limited to sexual intercourse, between clinical mental health counselors and clients is specifically in violation of this code of ethics. This does not, however, prohibit the use of explicit instructional aids including films and video tapes. Such use is within accepted practices of trained and competent sex therapists.

## Principle 4: Public statements

Clinical mental health counselors in their professional roles may be expected or required to make public statements providing counseling information, professional opinions, or supply information about the availability of counseling products and services. In making such statements, clinical mental health counselors take full account of the limits and uncertainties of present counseling knowledge and techniques. They represent, as objectively as possible, their professional qualifications, affiliations, and functions, as well as those of the institutions or organizations with which the statements may be associated. All public statements, announcements of services, and promotional activities should serve the purpose of providing sufficient information to aid the consumer public in making informed judgments and choices on matters that concern it.

a. When announcing professional services, clinical mental health counselors limit the information to: name, highest relevant degree conferred, certification or licensure, address, telephone number, office hours, cost of services, and a brief explanation of the types of services offered but not evaluative as to their quality of uniqueness. They will not contain testimonials by implication. They will not claim uniqueness of skill or methods beyond those available to others in the profession unless determined by acceptable and public scientific evidence.

b. In announcing the availability of counseling services or products, clinical mental health counselors will not display their affiliations with organizations or agencies in a manner that implies the sponsorship or certification of the organization or agency. They will not name their employer or professional associations unless the services are in fact to be provided by or under the responsible, direct supervision and continuing control of such organizations or agencies.

c. Clinical mental health counselors associated with the development or promotion of counseling device, books, or other products offered for commercial sale will make every effort to insure that announcements and advertisement are presented in a professional and factually informative manner without unsupported claims of superiority; [all information] must be supported by scientifically acceptable evidence or by willingness to aid and encourage independent professional scrutiny or scientific test.

d. Clinical mental health counselors engaged in radio, television or other public media activities will not participate in commercial announcements recommending to the general public the purchase or use of any proprietary or single-source product or service.

e. Clinical mental health counselors who describe counseling or the services of professional counselors to the general public accept the obligation to present the material fairly and accurately, avoiding misrepresentation through sensationalism, exaggeration or superficiality. Clinical mental health counselors will be guided by the primary obligation to aid the public in forming their own informed judgments, opinions and choices.

f. As teachers, clinical mental health counselors ensure that statements in catalogs and course outlines are accurate, particularly in terms of subject matter to be covered, bases for grading, and nature of classroom experiences. As practitioners providing private services, CMH counselors avoid improper, direct solicitation of clients and the conflict of interest inherent therein.

g. Clinical mental health counselors accept the obligation to correct others who may represent their professional qualifications or associations with products or services in a manner incompatible with these guidelines.

## Principle 5: Confidentiality

Clinical mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of teaching, practice, or research. Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society. Disclosures of counseling information are restricted to what is necessary, relevant, and verifiable.

a. All materials in the official record shall be shared with the client who shall have the right to decide what information may be shared with anyone beyond the immediate provider of service and to be informed of the implications of the materials to be shared.

b. The anonymity of clients served in public and other agencies is preserved, if at all possible, by withholding names and personal identifying data. If external conditions require reporting such information, the client shall be so informed.

c. Information received in confidence by one agency or person shall not be forwarded to another person or agency the client's written permission.

d. Service providers have a responsibility to insure the accuracy and to indicate the validity of data shared with their parties.

e. Case reports presented in classes, professional meetings, or in publications shall be so disguised that no identification is possible unless the client or responsible authority has read the report and agreed in writing to its presentation or publication.

f. Counseling reports and records are maintained under conditions of security and provisions are made for when they have outlived their usefulness. Clinical mental health counselors insure that privacy destruction and confidentiality are maintained by all persons in the employ or volunteers and community aides.

g. Clinical mental health counselors who ask that an individual reveal personal information in the course of interviewing, testing or evaluation, or who

who allow such information to be divulged, do so only after making certain that the person or authorized representative is fully aware of the purposes of the interview, testing or evaluation and of the ways in which the information will be used.

h. Sessions with clients are taped or otherwise recorded only with their written permission or the written permission of a responsible guardian. Even with guardian written consent, one should not record a session against the expressed wishes of a client.

i. Where a child or adolescent is the primary client, the interests of the minor shall be paramount.

j. In work with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts which should remain the property of each family member.

## Principle 6: Welfare of the consumer

Clinical mental health counselors respect the integrity and protect the welfare of the people and groups with whom they work. When there is a conflict of interest between the client and the clinical mental health counselor employing institution, the clinical mental health counselors clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Clinical mental health counselors fully inform consumers as to the purpose and nature of any evaluative treatment, educational or training procedure, and they freely acknowledge that clients, students, or subjects have freedom of choice with regard to participation.

a. Clinical mental health counselors are continually cognizant both of their own needs and of their inherently powerful position "vis-a-vis" clients, in order to avoid the client's trust and dependency. Clinical mental health counselors make every effort to avoid dual relationships with clients and/or relationships which might impair their professional judgment or increase the risk of client exploitation. Examples of such dual relationships include treating an employee or supervisor, treating a close friend or family relative and sexual relationships with clients.

b. Where clinical mental health counselors' work with members of an organization goes beyond reasonable conditions of employment, clinical mental health counselors recognize possible conflicts of interests that may arise. When such conflicts occur, clinical mental health counselors clarify the nature of the conflict and inform all parties of the nature and directions of the loyalties and responsibilities involved.

c. When acting as supervisors, trainers, or employers, clinical mental health counselors accord recipients informed choice, confidentiality, and protection from physical and mental harm.

d. Financial arrangements in professional practice are in accord with professional standards that safeguard the best interests of the client and that are clearly understood by the client in advance of billing. This may best be done by the use of a contract. Clinical mental health counselors are responsible for assisting clients in finding needed services in those instances where payment of the usual fee would be a hardship. No commission or rebate or other form of remuneration may be given or received for referral of clients for professional services, whether by an individual or by an agency.

e Clinical mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the clients' ability to make an informed choice when selecting a service provider. This responsibility includes a clear written description of what the client may expect in the way of tests, reports, billing, therapeutic regime and schedules.

f. Clinical mental health counselors who find that their services are not beneficial to the client have the responsibility to make this known to the responsible persons.

g. Clinical mental health counselors are accountable to the parties who refer and support counseling services and to the general public and are cognizant of the indirect or long-range effects of their intervention.

h. The clinical mental health counselor attempts to terminate a private service or consulting relationship when it is reasonably clear to the clinical mental health counselor that the consumer is not benefitting from it. If a consumer is receiving services from another mental health professional, clinical mental health counselors do not offer their services directly to the consumer without informing the professional persons already involved in order to avoid confusion and conflict for the consumer.

## Principle 7: Professional relationship

Clinical mental health counselors act with due regard to the needs and feelings of their colleagues in counseling and other professions. Clinical mental health counselors respect the prerogatives and obligations of the institutions or organizations with which they are associated.

a. Clinical mental health counselors understand the areas of competence of related professions and make full use of other professional, technical, and administrative resources which best serve the interests of consumers. The absence of formal relationships with other professional workers does not relieve clinical mental health counselors from the responsibility of securing for their clients the best possible professional service; indeed, this circumstance presents a challenge to the professional competence of clinical mental health counselors, requiring special sensitivity to problems outside their areas of training, and foresight, diligence, and tact in obtaining the professional assistance needed by clients.

b Clinical mental health counselors know and take into account the traditions and practices of other professional groups with which they work and cooperate fully with members of such groups when research, services, and other functions are shared or in working for the benefit of public welfare.

c. Clinical mental health counselors strive to provide positive conditions for those they employ and that they spell out clearly the conditions of such employment. They encourage their employees to engage in activities that facilitate their further professional development.

d. Clinical mental health counselors respect the viability, reputation, and the proprietary right of organizations which they serve. Clinical mental health counselors show due regard for the interest of their present or prospective employers. In those instances where they are critical of policies, they attempt to effect change by constructive action within the organization.

e. In the pursuit of research, clinical mental health counselors give sponsoring agencies, host institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. They are aware of their obligation to future research workers and insure that host institutions are given feedback information and proper acknowledgement.

f. Credit is assigned to those who have contributed to a publication, in proportion to their contribution.

g. When a clinical mental health counselor violates ethical standards, clinical mental health counselors should know first-hand of such activities should, if possible, attempt to rectify the situation. Failing an informal solution, clinical mental health counselors should bring such unethical activities to the National Academy of Certified Clinical Mental Health Counselors.

## Principle 8: Utilization of assessment techniques

In the development, publication, and utilization of counseling assessment techniques, clinical mental health counselors follow relevant standards. Individuals examined, or their legal guardians, have the right to know the results, the interpretations made, and where appropriate, the particulars on which final judgment was based. Test users should take precautions to protect test security but not at the expense of an individual's right to understand the basis for decisions that adversely affect that individual or that individual's dependents.

a. The client has the right to have and the provider has the responsibility to give explanations of test results in language the client can understand.

b. When a test is published or otherwise made available for operational use, it should be accompanied by a manual (or other published or readily available information) that makes every reasonable effort to describe fully the development of the test, the rationale, specifications followed in writing items analysis or other research. The test, the manual, the record forms and other accompanying material should help users make correct interpretations of the test results and should warn against common misuses. The test manual should state explicitly the purposes and applications for which the test is recommended and identify any special qualifications required to administer the test and to interpret it properly. Evidence of validity and reliability, along with other relevant research data, should be presented in support of any claims made.

c. Norms presented in test manuals should refer to defined and clearly described populations. These populations should be the groups with whom users of the test will ordinarily wish to compare the persons tested. Test users should consider the possibility of bias in tests or in test items. When indicated, there should be an investigation of possible differences in validity for ethnic, sex, or other subsamples that can be identified when the test is given.

d. Clinical mental health counselors who have the responsibility for decisions about individuals or policies that are based on test results should have a thorough understanding of counseling or educational measurement based and of validation and other test research.

e. Clinical mental health counselors should develop procedures for systematically eliminating from data files test score information that has, because of the lapse of time, become obsolete.

f. Any individual or organization offering test scoring and interpretation services must be able to demonstrate that their programs are based on appropriate research to establish the validity of the programs and procedures used in arriving at interpretations. The public offering of an automated test interpretation service will be considered as a professional-to-professional consultation. In this formal responsibility of the consultant is to the consultee but his/her ultimate and overriding responsibility is to the client.

g. Counseling services for the purpose of diagnosis, treatment, or personalized advice are provided only in the context of a professional relationship, and are not given by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, mail, or similar media. The preparation of personnel reports and recommendations based on test data secured solely by mail is unethical unless such appraisals are an integral part of a continuing client relationship with a company, as a result of which the consulting clinical mental health counselor has intimate knowledge of the client's personal situation and can be assured thereby that his written appraisals will be adequate to the purpose and will be properly interpreted by the client. These reports must not be embellished with such detailed analysis of the subject's personality traits as would be appropriate only for intensive interviews with the subjects.

## Principle 9: Pursuit of research activities

The decision to undertake research should rest upon a considered judgment by the individual clinical mental health counselor about how best to contribute to counseling and to human welfare. Clinical mental health counselors carry out their investigations with respect for the people who participate and with concern for their dignity and welfare.

a. In planning a study the investigator has the personal responsibility to make a careful evaluation of its ethical acceptability, taking into account the following principles for research with human beings. To the extent that this appraisal, weighing scientific and humane values, suggests a deviation from a principle, the investigator incurs an increasingly serious obligation to seek ethical advice and to observe more stringent safeguards to protect the rights of the human research participants.

b. Clinical mental health counselors know and take into account the traditions and practices of other professional groups with members of such groups when research, services, and other functions are shared or in working for the benefit of public welfare.

c. Ethical practice requires the investigator to inform the participant of all features of the research that reasonably might be expected to influence willingness to participate, and to explain all other aspects of the research about which the participant inquires. Failure to make full disclosure give added emphasis to the investigator's abiding responsibility to protect the welfare and dignity of the research participant.

d. Openness and honesty are essential characteristics of the relationship between investigator and research participant. When the methodological requirements of a study necessitate concealment or deception, the investigator is required to insure as soon as possible the participant's understanding of the reasons for this action and to restore the quality of the relationship with the investigator.

e. In the pursuit of research, clinical mental health counselors give sponsoring agencies, host institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. They are aware of their obligation to future research workers and insure that host institutions are given feedback information and proper acknowledgement.

f. Credit is assigned to those who have contributed to a publication, in proportion to their contribution.

g. The ethical investigator protects participants from physical and mental discomfort, harm and danger. If the risk of such consequences exists, the investigator is required to inform the participant of that fact, secure consent before proceeding, and take all possible measures to minimize distress. A research procedure may not be used if it is likely to cause serious and lasting harm to participants.

h. After the data are collected, ethical practice requires the investigator to provide the participant with a full clarification of the nature of the study and to remove any misconceptions that may have arisen. Where scientific or humane values justify delaying or withholding information the investigator acquires a special responsibility to assure that there are no damaging consequences for the participants.

i. Where research procedures may result in undesirable consequences for the participant, the investigator has the responsibility to detect and remove or correct these consequences, including, where relevant, long-term after effects.

j. Information obtained about the research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality be explained to the participants as a part of the procedure for obtaining informed consent.

## CHAPTER 7

# CONSULTATION IN SCHOOLS AND MENTAL HEALTH AGENCIES: MODELS AND METHODS

Consultation is one of the most sought after services rendered by counselors and psychologists. During the last decade and with the passage of the Community Mental Health Act of 1963, consultation has become recognized as a more broadly defined helping process (Kurpius, 1978). Kurpius suggested that the intent of this early legislation was to urge the helping professions to move from individual and small group remedial activities as the primary care giving intervention toward more developmental and preventive approaches.

## DEFINITION

With the growth of consultation, a diversity of opinion has developed with regard to the definition of consultation and the focus of consultation. A review of the literature by Alpert and Meyers (1983) fails to provide an agreed upon definition of consultation. Ohlsen (1983) defined consultation as an activity in which a professional helps another person in regard to a third. Caplan (1970) views consultation as a collaborative process between two professionals who both have their own area of expertise. Albee (1982) defined consultation in terms of a preventive approach to service delivery in mental health. Kirby (1985, p. 9) defined consultation in terms of four relationship conditions: (1) the relationship is voluntary, (2) the focus of attention is on the problem situation as articulated by the consultee(s), (3) the consultant is not functioning as a part of the structural hierarchy, and (4) the power that resides in consultant's expertise is sufficient to facilitate change. For purpose of clarity, the definition provided by Meyers, Parsons, and Martin (1979) will be used in this chapter.

> Consultation is a helping or problem solving process occurring between a professional help giver and helpseeker who has responsibility for the welfare of another person. It is a voluntary relationship in which the help giver and a help seeker share in solving a current problem of the help seeker. The help seeker profits from the relationship in such a way that future problems may be handled more positively and skillfully. (p. 4)

Similarly, authors disagree with reference to the focus of consultation. Alpert (1977) suggested that consultation is a direct service provided by counselors and psychologists. Caplan (1970) viewed direct service as a part of the overall process of consultation. Meyers, Parsons, and Martin (1979) suggested that consultation and direct service should be viewed as being on opposite ends of a continuum.

The important point to note is that traditionally, counselors and psychologists have been involved in providing direct service to clients. Direct service implies that the focus of consultation is on the individual client and the intrapersonal factors affecting him/her. Typically taking the form of crisis intervention, direct service is thought to consist of psychodiagnosis and counseling, as the primary remedial activities of the counselor/therapist.

More recently, attention has been focused upon the counselor and psychologist providing preventive approaches to service delivery (Conyne, 1987). The indirect service approach stresses the consultation efforts directed to understanding the environment of the client with interventions aimed at assisting the professional who has responsibility for a caretaker role with the individual.

With the development of indirect service approaches, the counselor/psychologist must ensure that role confusion does not hamper the delivery of mental health services. An important point to assure is that counseling and consultation are seen as different but complimentary forms of intervention. Bloom (1977) suggested that consultation differs from counseling/therapy in that the consultant does not assume the full responsibility for the final outcome of consultation. The consultant's role is to develop and enhance the work of the consultee rather than in counseling where the focus is upon personal improvement of the client. Thus, the consultant must remember that the relationship established with the consultee is not primarily therapeutic in nature. Rather, the consultant serves in the capacity of collaborator and facilitator, to assist the consultee in performing his/her duties and responsibilities in a more productive and effective manner (p. 156).

Bloom (1977) recognized the importance of distinguishing consultation from other forms of mental health activities. He stated that consultation is different from supervision on the grounds that (1) the consultant may not be of the same professional specialty as the consultee, (2) the consultant has no administrative responsibility for the work of the consultee, (3) consultation may be more irregular in character than continuous, and (4) the consultant is not in a position of power with respect to the consultee. Similarly, Bloom (1977) differentiated consultation from counseling because in the process of counseling a clear contractual relationship exists between an individual designated as a client and another individual designated as counselor. Also, the goal of consultation is improved work performance whereas in counseling the goal is personal adjustment (p. 156).

In the remainder of this Chapter will be provided an overview and discussion of mental health consultation and school consultation models that are applicable to the practicum student and intern in counseling and psychology.

## MENTAL HEALTH CONSULTATION

Mental health consultation has been widely influenced by the writing of Gerald Caplan. With the writing of the book entitled *The Theory and Practice of Mental Health Consultation* in 1970, Caplan identified four consultation types that are employed in mental health settings.

The four types of consultation are summarized to provide the practicum student and intern with an overview of mental health models.

> ***Client Centered Case Consultation**—A consultee has difficulty in dealing with the mental health aspects of one of his/her clients and calls in a specialist to investigate and advise on the nature of the difficulties and on what the consultee should do about them. The consultee's work difficulty relates to the management of a particular case or group of cases. The consultant makes an assessment of the client's problem and recommends how the consultee should proceed.
>
> ***Program Centered Administrative Consultation**—The consultant is invited by an administrator to help with a current problem of program development, with some predicament in the organization of their institution, or with planning and implementation of organizational policies, including personal policies. The consultant is expected to provide feedback to the organization in the form of a written report.
>
> ***Consultee Centered Case Consultation**—Consultee's work problem relates to the management of a particular client and he/she invokes the consultant's help in order to improve handling of the case. The consultant's primary focus is upon clarifying and remedying the shortcomings in the consultee's professional functioning that are responsible for his difficulties with the case about which he/she is seeking help.
>
> ***Consultee-Centered Administrative Consultation**—The consultant helps the administrative staff of an organization to deal with current problems in organizational planning, program development, of organizational policies. The focus of attention is the

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*Adapted.

consultee's work difficulties and attempting to help improve his/her problem solving skills (Caplan, 1970, pp. 109-50).

Caplan further described what he considered to be the characteristics of mental health consultation. A summary of Caplan's characteristics are presented to give the student a clear understanding of the consultation model in mental health settings.

1. Mental health consultation is a method for use between two professionals in respect to a lay client or a program of such clients.
2. The consultee's work problem must be defined by him/her as being in the mental health area—relating to (a) mental disorder or personality idiosyncrasies of the client, (b) promotion of mental health in the client, or (c) interpersonal aspects of the work situation.
3. The consultant has no administrative responsibility for the consultee's work or professional responsibility for the outcome of the client's case.
4. The consultee is under no compulsion to accept the consultant's ideas or suggestions.
5. The basic relationship between the two is coordinate. No built in hierarchial authority tension exists.
6. The coordinate relationship is fostered by the consultant's usually being a member of another profession and coming briefly into the consultee's institution from the outside.
7. Consultation is usually given as a short series of interviews—which take place intermittently in response to the consultee's awareness of current need for help with a work problem.
8. Consultation is expected to continue indefinitely.
9. A consultant has not predetermined a body of information that he/she intends to impart on a particular consultee.
10. The twin goals of consultation are to help the consultee improve his/her handling or understanding of the current work difficulty and to increase his/her capacity to master future problems of a similar type.
11. The aim is to improve the consultee's job performance and not his/her sense of well being.
12. Consultation does not focus overtly on personal problems and feelings of the consultee.
13. This doesn't mean that the consultant does not pay attention to the feelings of the consultee. He/she is particularly sensitive to these and to the disturbance of task functioning produced by personal problems.
14. Consultation is usually only one of the professional functions of specialists, even if he/she is formally entitled "consultant."
15. Finally, mental health consultation is a method of communication between a mental health specialist and other professionals (pp. 28-30).

The understanding of the stages and types of consultation and the characteristics of mental health counseling enable the student to begin to conceptualize an approach to consultation in light of their own needs as well as the needs of the consultee. The necessity of understanding a wide range of theoretical perspectives in consultation is stressed by Jacobson, Ravlin, and Cooper (1983). These authors conceptualized mental health consultation as a multilinear model. The first step in the model is the development and implementation of a formal intervention plan requiring the consultant to have summarized the available information about the recipient organization into a useful systems assessment. The second step is entry into the system which denotes the first formal contact between the two systems regarding the current consultation. Entry must be seen in the context of the agencies history. Third step, relationship building is a long term process that transcends the time constraints of a particular consultation agreement—thus it is conceptualized as an on-going process. Fourth step, formal interventions follow the mediation of a consultation agreement. Fifth step, the agreement is often negotiated earlier in the consultation process, the agreement generally undergoes repeated modification in the course of the intervention process based upon the ongoing system assessment and program evaluation. Sixth step, conclusion of the services provided by specific consultation is often the precursor to subsequent cycling of the consultative process. Consequently, the termination of a consultation agreement rarely is as final as it is in clinical interventions (Jacobson, Ravlin, & Cooper, 1983, pp. 58-60).

## SCHOOL CONSULTATION

Current interest in school consultation is part of a broader professional trend emphasizing preventive mental health, indirect service delivery, community interventions, and new sources of mental health manpower (Meyers, Parsons, & Martin, 1979).

Historically, consultation in the schools has its roots in disciplines other than education. The fields of psychiatry, group dynamics, psychology, and organizational development have all contributed to the development of models of school consultation. Likewise authors such as Caplan (1970) and Sarason (1971) have focused attention on the need for a coordinated sharing of expertise by professionals in the schools. The writings of these individuals have changed the focus of consultation from advice giving in the early years to a more coordinate, expertise-sharing process. They also have augmented the consultant's knowledge of the school as a culture and as an organization. Finally, they have contributed to a variety of techniques other than in—service education and case feedback, including group dynamics exercises, applied research techniques theme, interference reduction, organizational development techniques, and conflict resolution procedures (Meyers, Parsons, & Martin, 1979, pp. 35-6).

Similar to mental health consultation, school consultation has generated a number of models for intervention in the schools. Parsons and Meyers (1984) discussed a model of school consultation with a focus on primary and secondary prevention. In the model are defined four categories of consultation in the schools.

> **Direct Service to the Client**—Consultation seeks to modify the behavior, attitudes, or feelings of a particular client or clients who present a problem or problems. Data about the client are gathered directly by the consultant using individual testing, interviewing, and behavioral observation of the client.
>
> **Indirect Service to the Client**—Consultation aims to change the behavior, attitude, or feelings of the client(s). In contrast, data are not gathered directly by the consultant. Instead the consultee gathers the necessary data to be shared with the consultant.
>
> **Service to the Consultee**—The target for service is the consultee rather than the consultee's client. The goal is to change the behavior, attitudes, or feelings of the consultee.
>
> **Service to the System**—The target for service is to improve the organizational functioning of the system as a whole. This result should lead to improved mental health for both clients and individual consultee's in the organization (pp. 5-6).

Lambert (1983) discussed consultation in the schools as an interaction between a teacher and a school district employee from a mental health discipline. Although this model assumes that the consultant is school based, nevertheless the steps in the process are the same for consultants brought in from outside the system. Lambert (1983) suggested that the process of consultation is initiated (1) when a teacher requests help, (2) when a consultant offers to assist a teacher or pupil, or (3) when a principal requests help for a teacher or himself/herself. The objectives of school based consultation may be a change in pupil behavior or a change in teacher behavior or both (p. 31). Lambert further elaborated what are considered to be the phases involved in school consultation. The first phase is identified as the relationship building-role clarification phase in which the consultant defuses teacher anxiety about being analyzed, exposed, and evaluated and during which time the consultant interacts so as to be seen as a helpful, nonjudgmental, and knowledgeable person. The second phase which follows several weeks later, consists of a problem identification and the generation of intervention strategies. During this time, teachers and consultant are actively discussing cases, successfully sharing information from each of their professional perspectives, and developing alternative interventions to be considered and tried. The third and final phase occurs when the teacher and consultant each understand the other's role, the teacher knows how to ask questions and can use the interaction to explore, propose, and rule out solutions. The relationship has become one in which two professional peers can effectively use one another in exploration and discussion of matters of mutual concern (pp. 32-3).

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# GUIDELINES FOR SCHOOL AND MENTAL HEALTH CONSULTATION

John C. Boylan

This section is presented to assist the practicum student and intern in formulating his/her plan for initiation consultation in schools or mental health agencies. The stages of consultation outlined by Meyers, Parsons, and Martin (1979) has been *adapted* and serve as guidelines for the development of the consultation plan.

**Enter into the System**

The consultant's entry into the system is a crucial step in determining the success or failure of consultation efforts. Gallessich (1982) has delineated several steps in the process of formal entry into the system. For the external consultant, entry usually begins with the exploration of the match between the organization needs and the consultant's skill. Discussions between the consultant and members of the organization center around descriptive information about the organization, its needs, and desired outcomes. The consultant's skills, style of consultation, and a plan of how consultation efforts can be implemented in the setting are discussed and negotiated. Once the parties have agreed that consultation is indeed needed, the process proceeds to the negotiation of an informal or formal contract. The formulation of a contract follows the consultant having defined his/her function and role in the system. A clear understanding of the specific duties and functions of the consultant must be presented to personnel involved in the consultation effort. Negotiating a contract with key personnel serves to insure that the highest level of administrators as well as subordinates participate in the consultation process. Involvement of all personnel provides a smooth transition into the system and lessens the amount of resistance that can be encountered.

The formal discussion of the contract should include:

...goals or intended outcomes of consultation

...identity of the consultees

...confidentiality of service and the limits of confidentiality time frame—how long will the service be provided to the organization? To the individual consultee?

...time(s) the consultant will be available

...procedures for requesting to work with the consultant

...how to contact the consultant if needed

...possibility of contract renegotiation if change is needed

...fees, if relevant

...consultant's access to different sources and types of information within the organization

...person to whom the consultant is responsible (Brown, Pryzwansky, & Schulte, 1987, p. 137).

## ORIENTATION TO CONSULTATION

Orientation to consultation requires the consultant to communicate directly with key personnel in the system. Personnel need to know what to expect from the consultant and the consultant relationship. Initially the consultant, in establishing a working relationship, must discuss roles the consultant and consultees will play in the process. This enables all parties to share in the expression of their needs and preferences and creates an atmosphere of open discussion and communication. Typical questions addressed in the orientation include the following:

...What are the consultee's expectations about consultation?

...What role with the consultant and consultee assume in the consultative effort?

...What are the parameters of the consultant's interventions?

...What are the ethical concerns of the consultee? The consultant?

...What are the parameters of confidentiality?

...How long will the consultation take?

...What are the procedures governing the gathering of data?

...What are the guidelines for the giving and receiving of feedback?

...What are the procedures used in the assessment of the consultation plan?

## PROBLEM IDENTIFICATION

Once the consultant and consultee have oriented themselves to the process of consultation, the consultant needs to identify the problem(s) to be addressed. A first step in problem identification is to meet with the consultee to gather appropriate data. Problem identification begins with establishing the goals and objectives to be accomplished in consultation. Specific outcomes to be expected and the format for assessing outcomes is discussed. For example, questions to be considered might include the following:

What are your general concerns about the problem?

What needs to be accomplished to overcome your concerns?

What role with the consultant play in overcoming the problem?

What role will the consultee play in overcoming the problem?

What aspects of the consultee's problem are most distressing?

## CONSULTATION INTERVENTIONS

Having defined the problem and reviewed the data gathered with the consultee, the consultant proceeds with the development of a specific intervention plan. The plan will include the establishment of objectives, the selection of strategies to be implemented, and the assessment procedures to be followed. Bergan (1977) suggested the following outline as part of implementing a consultation plan.

1. Make sure that consultee and consultant agree upon the nature of the problem.
2. Complete either the setting and intrapersonal analysis or skill analysis.
3. Design a plan to deal with the identified problem.
   a. establish objectives
   b. select interventions
   c. consider barriers to implementation
   d. select assessment procedures.
4. Make arrangements for follow up sessions with the consultee.

## ASSESSING THE IMPACT OF CONSULTATION

The success or failure of the consultation interventions is determined by assessing the degree to which the results are congruent with the specific objectives. Data for making this determination comes from the observations that began during the entry process and have continued throughout the consultation process. Brown, Pryzwansky, and Schulte (1987) suggested that steps in evaluation process are as follows:

**Determine the Purposes(s) of the Evaluation**—The extent to which consultees provide or gather data effects their involvement at this point. The opportunity to make choices that will affect the time that needs to be directed to evaluation as well as the types of information that are collected will contribute to the ownership of the evaluation. A major issue to be considered is the confidentiality of the information to be presented.

**Agree on Measurements to be Made**—The consultant and consultee must agree on methods and procedures of measurement. Measures must specifically address the objectives and goals of the intervention plan.

**Identify Data Gathering Techniques**—The major goal here is to place the measures in a context which allows for their interpretation. Data gathering techniques include systematic observations, standardized tests, questionnaires, and feedback forms.

**Set a Data Collection Schedule**—The consultant and consultee agree upon a formalized calendar of data collection. The method of collection, the tasks assigned to each party, and the method for summarizing and reporting data are discussed.

**Develop a Dissemination Plan**—The dissemination plan—which includes the format in which data is reported—needs to be carefully considered by both parties. Issues surrounding the reporting of data; the individuals to whom data are reported; the confidentiality of the data is agreed upon and follows a predetermined plan of action.

**Concluding Consultation**—The termination of the consultation process is as important as the initial entry into the system. An imperative step is for the consultant to provide the consultee with an open invitation to seek further assistance as the need arises. Follow up of consultation activities insures that the consultant and the consultee have the opportunity to measure the effects of the process over time. The degree to which the termination process is perceived as a smooth transition can determine whether consultation services will be sought in the future (pp. 243-4).

The *Consultation Rating Form* (Form 7.1) is provided for use by the site supervisor and university supervisor to evaluate consultation activities carried out by the counseling or psychology intern. The form can be used as an Interim or Final Evaluation.

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# NOTES

# CONSULTATION RATING FORM

John C. Boylan, Ph.D.

**DIRECTIONS:** For each of the following questions, please rate the degree to which you feel consultation was successful: 1. Highly successful, 2. Moderately Successful, 3. Neutral, 4. Not successful.

---

The consultant clearly defined his/her role to the staff. __________

The consultant emphasized the importance of the services offered on a request or voluntary basis. __________

The consultant stressed the importance of the services offered on a request or voluntary basis. __________

The consultant explained the rationale for his/her consultative approach. __________

The consultant encouraged open discussion of any problem or observations about the process of consultation. __________

The consultant was open to suggestions and recommendations from the consultee. __________

The consultant explained and described the steps in teh consultation process. __________

The consultant spent time carefully gathering data from the consultee. __________

The consultant intervened with direct services to the consultee. __________

The consultant intervened with indirect services to the consultee. __________

The consultant was successful in identifying the problem. __________

The consultant defined the problem in terms of the person in the environment. __________

The consultant defined the problem in terms of lack of skill, lack of knowledge. __________

The consultant defined the problem in terms of broader organizational problems or issues. __________

The consultant made specific recommendations for change. __________

The consultant provided a variety of interventions and strategies in problem solving. __________

The consultant evaluated the impact of his/her consultation efforts in a formal manner. __________

The consultant provided feedback to the consultee about the assessment of the consultation process. __________

The consultant encouraged follow up of the consultation relationship. __________

The consultant encouraged the independent problem solving by the consultee. __________

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## CHAPTER 8

# RECOGNIZING AND MANAGING CRITICAL CLIENT PROBLEMS

This chapter of the Practicum/Internship Text is organized to aid students in the recognition and management of critical client problems. The specific problems are as follows: (1) suicide, (2) harm to others, (3) substance abuse, and (4) child abuse.

Practicum students and interns need to learn what specific symptoms are associated with each of these problem areas and what therapeutic techniques are most useful in solving the problem. Of equal importance in the learning process is the value of supervision. Students must be knowledgeable of how and when to seek supervision in these areas. Supervision is vital to the development of student competence. Also, supervision provides a vehicle whereby students can learn about their school/agencies' policies regarding these issues.

In the material presented are the ethical/legal considerations related to each problem area. As conditions change, ethical and legal advancements occur and the commonly accepted system of practice changes. Practicum students and interns should be aware of these changes and integrate them into their practice.

* * *

## SUICIDE: A GUIDE FOR PRACTICUM STUDENTS AND INTERNS

Patrick B. Malley

Beauchamp (1980) defined suicide in the following manner:

1. that person intentionally brings about his or her own death;
2. others do not coerce him or her to do the actions; and
3. death is caused by conditions arranged by the person for the purpose of bringing about his or her own death.

Practicum students and interns frequently encounter suicidal clients in their counseling activities. Treating a suicidal client is an especially important task. What a student does or does not do in this counseling process may have far-reaching effects on the client's ultimate behavior.

The following areas represent skills and knowledge practicum students and interns should obtain in order to counsel suicidal clients:

A. have awareness of their ethical mandates,

B. have awareness of their legal restrictions,

C. know what presenting symptoms are characteristic of clients who attempt and succeed at suicide,

D. learn the skills and knowledge necessary to counsel suicidal clients,

E. know how and when to consult with their supervisors about suicidal clients, and

F. know the policies of their institutions regarding suicidal clients.

## Ethics and Suicide

A summary of selected ethical codes as they pertain to confidentiality and the suicidal client follows:

Ethical Standards, American Association for Counseling and Development

> When the client's condition indicates that there is clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities. Consultation with other professionals must be used where possible. The assumption of responsibility for the client(s) behavior must be taken only after careful deliberation. The client must be involved in the resumption of responsibility as quickly as possible.

Code of Professional Ethics, American Association for Marriage and Family Therapy

> Information is not communicated to others without consent of the client unless there is clear and immediate danger to an individual or to society, and then only to the appropriate family members, professional workers, or public authorities.

Standards for the Private Practice of Clinical Social Work, National Association of Social Workers

> The social worker should share with others confidences revealed by clients, without their consent, only for compelling professional reasons.
>
> The clinical social worker in private practice may find it necessary to reveal confidential information disclosed by the patient to protect the patient or the community from imminent danger.

Principles of Medical Ethics with Annotations especially applicable to Psychiatry, American Psychiatric Association

> Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

Ethical Principles of Psychologists, American Psychological Association

> Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.

## The Legal System and Suicide

Suicidal patients, by definition, contribute to their own death. Liability, however, is not lessened in suicidal cases. In suicide cases responsibility is taken away from the client and placed into the hands of parties who have assumed care for the patient. Consequently, psychotherapists or hospitals can be held to a standard of care in treating a patient, although they can never guarantee that suicide will be prevented (Slawson, Flinn, & Swartz, 1974).

What is a standard of care? How is the standard established? One way a court establishes a standard is to summon people who practice the same profession as the person accused of violating the standard of care. The court requires these professionals to testify if the behavior of the accused was what they, as prudent and reasonable members of the profession, would approve. If, in the opinion, of these expert witnesses, the accused did or did not do something that was in violation of acceptable professional standards, the accused may be found guilty of negligence and malpractice.

Note that, although many malpractice suits are brought against physicians, the need to establish a standard of care belongs to mental health professionals as well. The counseling relationship is a special one based on trust and faith, and the legal restraints on it are the same as the special relationship between the physician-patient (Knapp & Vandecreek, 1983).

The following cases (Rachlin, 1985)* taken from the legal literature are exemplary of how judges evaluate legal malpractice claims involving clients who have committed suicide:

### CASE 1

> Mr. A. was discharged from the Army in May, 1966, with a 30% service-connected disability based on a diagnosis of paranoid schizophrenia. During the remainder of that year, he received outpatient treatment from the V.A. His first hospitalization occurred in January, 1967; from that time until his death 6 years later, he had a total of 12 admissions, each ending by his leaving the hospital without permission.

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*Reprinted by permission of the publisher from "Double Jeopardy: Suicide and Malpractice," by Stephen Rachlin, *General Hospital Psychiatry*, 6, 1985, pp. 304-5.

His recorded history of suicidal behaviors consisted of an overdose of Doriden in September, 1971, a threat in October, 1971, an attempt to jump out a window in March, 1972, and additional threats in December, 1972, resulting in what was to become his final admission. During that hospitalization, he frequently started fights, was impulsive and agitated, often requiring seclusion. The last such episode occurred, however, on January 10, 1973. A week later, the nurse's notes describe him as quiet, pleasant, and cooperative. Unspecified "staff" decided that he was suitable for transfer to an open ward with limited privileges. That same day, he went on unauthorized absence from the V.A. Hospital, and apparently killed himself by jumping in front of a freight train.

The patient's chart revealed that he had not been seen by a physician for a week prior to his transfer to the open unit, and the court concluded that this was an error. Additionally, the court held that, based on Mr. A's record of suicide attempts and impulsive behavior, he should have been considered a suicide risk, and that the acceptable standard of care would have required he be free of impulsivity for 2-3 weeks prior to the granting of privileges. [The expert witness who offered this opinion to the court did so based on the specifics of this patient's history, not as general principle (R. DiSilverio, personal communication)]. He would not have been transferred, the judge stated, if a proper psychiatric evaluation, which would have "detected the impulsive inclinations," had been performed. Thus, there was a deviation from the required standard of care. Since the suicide was felt by the court to have been reasonably foreseeable, the negligent transfer to the open ward was deemed the proximate cause of death, and recovery of damages was allowed.

## CASE 2

Mr. B died on July 27, 1976, after suffering his third cardiac arrest subsequent to a suicidal overdose of amitriptyline. His only prior suicide attempt occurred 5 years earlier, also by drug ingestion. During the intervening time, he received several courses of outpatient treatment, provided by the V.A., for recurring depression complicated by drug and alcohol abuse.

The most recent working diagnosis was that of paranoid schizophrenia and, early in 1976, he was started on Etrfon 4-25 and weekly group psychotherapy. He participated in treatment for 5 months, and required increasing doses of medication, to 12 tablets per day. After initial improvement, he apparently declined in psychologic health. His wife attributed this to what she felt was excessive medication, and on May 25, reported to the physician that she had confiscated some of his supply. The patient decided to attempt private treatment, but returned to the V.A. the next day, and received another prescription. Again, he changed his mind about the source of his care, and was hospitalized elsewhere. On June 10, he came back to the V.A. group to announce his intention to abandon that form of therapy; this was his last known treatment visit. Mr. B next disappeared, having gone to California, and returned a few days later, looking better. By early July he again deteriorated clinically and reportedly took 400-500 Etrafon tablets.

His widow alleged that the dosage prescribed was excessive and that the treatment was poorly monitored. The court concluded that no expert testimony established that the physician deviated from accepted standards of care or failed to exercise ordinary skill. Although the patient was on 12 tablets daily, he had responded favorably to the medication, required antidepressants, and was not acutely suicidal. Further, 300 mg per day of amitriptyline was within the parameters of safe practice, albeit at the outer limit. There could be no liability, the judge held, because the doctor's conduct (even if negligent) was not the proximate cause of the death. This decision was affirmed on appeal.

## CASE 3

Mr. C was a third-year medical student who in January, 1971 was admitted voluntarily to the psychiatric unit at the Downstate Medical Center for treatment of paranoid schizophrenia. The record revealed that staff had knowledge of his suicidal potential, and that the primary physician was a first year-resident. The patient met his death, in an unstated fashion, on April 22, the day he was first given off-ward privileges.

While there was a question as to whether reasonable care was exercised in the medical judgment not to restrict Mr. C to the ward, the issue on which the court's decision turned was the degree of supervision of treatment by a qualified (i.e., attending) psychiatrist. The attending physician testified that, as of a week before the patient's death, and based on her observations and discussions, she decided that he be prepared for discharge. Although she knew of his suicidal statements, there was no evidence of any attempts at self-destruction. However, she did not personally interview or carefully evaluate the patient's propensity for suicide.

The court held that the principle fault was with the lack of a clear policy requiring more active and direct management of patients by attending staff, and secondarily, with the failure by the qualified psychiatrist to keep detailed notes. Damages awarded to the widow were affirmed but, for reasons not germane to this report, were significantly reduced in amount by the appellate court; the state's highest court subsequently concurred.

**CASE 4**

Mr. D., a Phi Beta Kappa college graduate, was a patient at Bellevue Psychiatric Hospital during the Fall of 1974 and January, 1975. While awaiting a bed at the New York State Psychiatric Institute, he was released on a pass on January 30. Almost 2 months later, his body was found floating in the Hudson River near the George Washington Bridge (literally a stone's throw from P.I.). Despite the strong suggestive circumstance, there was no absolute proof that this death was a suicide.

A first-year resident was the treating doctor, and was the one who authorized the pass. Evidence was vague as to whether, by history, the patient had only threatened or actually attempted suicide. The medical record reflected supervision by an attending psychiatrist, whose initials were in the chart on or about the day in question. Furthermore, there was testimony that he had personally interviewed the patient "periodically." While the resident was apparently unaware of a nurse's note characterizing Mr. D. as "wasting away," the attending commented to the effect that, regardless of such a statement, in his opinion, the patient would not commit suicide.

The appellate court cited the Case 3 decision, and made a point of distinguishing the circumstances with regard to the degree of supervisory involvement by a fully qualified psychiatrist. Finding no negligence, they reversed a jury verdict in favor of the plaintiff, and unanimously dismissed the complaint; these actions were also upheld by the state's highest court. (pp. 304-5)

In conclusion, interns and practicum students need to be aware of the existing ethical and legal implications of their counseling practice. Not only are they an extant fact of life but they also are an intricate and inextricable part of their professional identity.

## Presenting Symptoms of Suicidal Clients

Patterson, Dohn, Bird, and Patterson (1983)* presented the following risk factors for the prompt and thorough evaluation of potentially suicidal patients, and they feel they are the risk factors that predict the possibility of eventual suicide:

**Sex.** Women attempt suicide three times more frequently than men, but men actually kill themselves more than three times as often as do women.

**Age.** There is bimodal distribution of suicide with peaks in the late teenage and elderly years. The high-risk category proposed by Tuckman and Youngman includes 45 or more years of age and being male as important risk factors. Patients 19 or younger or 45 or older are thus considered at higher risk for suicide.

**Depression.** Affective disorders and their relation to suicide have been examined extensively by Guze and Robins in their review of 17 studies. They showed that affective disorder is a significant factor in 12% to 60% of suicides. The average suicide rate was 30 times greater in depressives compared with the general population. They also suggested that about 15% of primary depressives die by suicide. Others have also found a diagnosis of depression to be a good predictor of suicidal behavior.

**Previous attempt.** Numerous studies demonstrate that 25% to 50% of persons who kill themselves have previously attempted to do so. In fact, suicide rate by previous attempters is up to 64 times higher than the overall rate in the population. A prior attempt not only increases the risk in the year following the attempt, but also increases the subsequent lifetime suicide rate.

**Ethanol abuse.** Early studies indicated an increased suicide rate in alcoholics. In fact, it is estimated that 15% of all alcoholics commit suicide, the suicide often coming as a late complication of chronic alcoholism and correlating well with the occurrence of cirrhosis. Later studies corroborate these findings and point up the importance of alcoholism in the suicide attempter.

**Rational thinking loss.** Any psychosis (e.g., schizophrenia, manic-depressive illness, organic brain syndrome) presents a hazard to the patient if judgment and rational thought are severely impaired and if he or she is delusional or hallucinating. It is difficult to establish rapport and trust with these individuals, not to mention the ever present danger of their hearing voices with instructions to hurt or kill themselves. Several authors have reported the presence of psychosis as a risk factor for suicide.

**Social supports lacking.** The suicidal patient often lacks significant others (relatives, friends), employment at a meaningful job, and religious support. Individually these supports may not be statistically significant, but collectively they represent a major and important factor to assess

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in suicidal patients. Many authors comment on this, especially in regard to recent loss of social support.

**Organized plan.** The person with a well-delineated, specific plan envisaging a lethal available method is at a far greater risk than others. The degree of organization is often shown by direct or indirect communication of suicidal intent, by seeking medical care or counseling prior to the attempt, by "getting one's affairs in order," and by suicide notes. In fact, over two thirds of the suicides in one study had communicated suicidal ideas, 41% specifically stating their intentions. The extent of planning of the attempt and the lethality of the plan are both factors requiring greater degrees of organization. Rosen studied a large group of suicide attempters and found that such organization meant that the serious attempter had a higher suicide risk than the less serious one.

**No spouse.** Divorced, widowed, separated, or single patients have a higher risk of suicide than married patients, especially those with children to reinforce the marriage.

**Sickness.** The role of physical illness is somewhat inconsistent in studies of suicidal patients, but chronic, debilitating, and severe illness is thought to be a definite risk factor. Suicidal patients often seek medical attention prior to their act, with illness often being directly involved in the outcome.

**Other factors.** Other characteristics have been mentioned as suicide risk factors, but they seem to play only a minor role in determining overall risk. Such items include race, geographic region of residence, religion, occupation, drug abuse, defenselessness, season, and genetic predisposition. However, they are inconsistent, less well documented, and of less practical importance to the average physician who is evaluating the potentially suicidal patient. (pp. 344-5)

Fujimura, Weis, and Cochran (1985) in their review of the literature also lists characteristics of potentially suicidal clients. These characteristics of lethality include the following:

1. **Previous suicide attempts.** This is the best single predictor of lethality. Attempts made by family members or close friends will exert an influence as well.
2. **Sleep disruption.** This can increase the intensity of depression. The person may be hallucinating, possibly from an excess of such drugs as stimulants and depressants.
3. **Definitiveness of plan.** The suicidal individual must be asked to talk about this, and he or she almost always will if asked. The more definitive plan, the more serious the intent.
4. **Reversibility of plan.** Time span is an important consideration. Using a gun or jumping from a high place are irreversible methods most of the time. Taking pills is less lethal because there is a better chance for reversibility.
5. **Proximity of others.** A person who really does not want to die will rely on intervention from other people. A person truly intent on committing suicide will ensure that no one can intervene.
6. **Giving possessions away.** The suicidal individual is likely to give prized possessions away, finalize his or her business affairs, or revise his or her will.
7. **A history of severe alcohol or drug abuse.** An individual who is dependent on drugs or alcohol is a greater suicide risk.
8. **A history of previous psychiatric treatment or hospitalization.** The suicidal individual is likely to have received previous psychiatric treatment or to have been hospitalized.
9. **Availability of resource and support systems.** Does the suicidal person realize that these systems exist, and do these groups realize that they are the person's source of support?
10. **Willingness to use resource and support systems.** A suicidal person's not using these systems signifies a cutting off of communication and makes the intent more serious. (p. 613)

Martin and Dixon's (1986) review of the literature concerning adolescent suicide is summarized as follows:

1. Depression is more readily detected among adults. Adolescents have natural mood swings.
2. Depressed adolescents, unlike depressed adults are often confused about their self-identity.
3. As many as twenty-five percent of suicidal adolescents experience an increase of social isolation before their suicide attempts.

4. Suicide is higher for married teenagers, and highest among those who are divorced.

5. The "typical" suicidal adolescent is a white, Anglo Saxon, Protestant female approximately 15 years of age. Her parents are divorced and her mother works full time.

**Intervening with the Suicidal Client**

Some techniques generally recognized by therapists tend to facilitate the counseling process for suicidal clients. Some of these techniques are as follows:

1. Be sure to listen intelligently, sensitively, and carefully to your client.
2. Accept and understand your client's suicidal thoughts.
3. Don't give false assurances to your client. Don't say things like "everything is going to be all right."
4. Be supportive to your client.
5. Assure your client of your availability.
6. Be firm with your client, while at the same time caring.
7. Don't use euphemisms. Use words like "you would like to kill yourself" rather than vague expressions of the problem.
8. Bring out any ambivalence the client has. Try to increase his/her choices.
9. If your client is in crisis, don't leave him/her alone.
10. Intervene in a search for hopefulness rather than helpfulness.
11. Intervene to dispose of any weapons the client might have.
12. Tell others, those who would be concerned and can help. You have already informed your client of the limits of confidentiality.
13. Help the client develop support systems.
14. Trust your own judgment.
15. Have available the suicide hot lines in your area.
16. Understand the procedures for commitment in your area.
17. Use available and appropriate scales for judging suicide risks.
18. Have the client sign a suicide contract.

The following pages provide examples of (1) an appropriate scale for judging suicidal risks and (2) a suicide contract.

The sad persons scale was published by Patterson et al. (1983). A point of 1 is given for every category the client falls into. These points are then summed and Table 2 is used as a guide to determine action with suicidal clients.

**TABLE I** **The Sad Persons Scale***

| | |
|---|---|
| S--Sex | 1 point for male |
| A--Age | 1 point if 19 or younger--45 or older |
| D--Depression | 1 point |
| P--Previous attempt | 1 point |
| E--Ethanol Use | 1 point |
| R--Rational thinking loss | 1 point |
| S--Social support lacking | 1 point |
| O--Organized Plan | 1 point |
| N--No spouse | 1 point |
| S--Sickness | 1 point |

**TABLE II** **Guidelines for Action***

| Total Points | Proposed Clinical Action |
|---|---|
| 0 to 2 | **send** home with follow up |
| 3 to 4 | **close** follow up consider hospitalization |
| 5 to 6 | **consider** strongly hospitalization |
| 7 to 10 | **hospitalize** or commit |

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If a determination is made that the client is possibly suicidal and will not consent to hospitalization, the practicum student or intern may use a written contract to help the client get through the time until the next appointment. An example of a suicide contract is presented in Sample 7.

At times an appropriate procedure is to have a client commit himself/herself to a hospital for treatment. If the client refuses, the case may be serious enough to warrant attempting an involuntary commitment to a treatment center. The procedures for commitment whether voluntary or involuntary vary a great deal from area to area. Also laws surrounding commitment procedures are quite different from state to state. For example, in Pennsylvania a minor over the age of fourteen can commit himself/herself to a hospital without parents' permission. The parents must be notified of the commitment and may demand the minor be released. In Ohio a minor over age fourteen may not be committed to a hospital without parental consent. However, upon commitment the minor must sign a release form before his/her parent or guardian may have access to the counseling records.

Specific behaviors and other presenting symptoms of potentially suicidal clients are

## SAMPLE SUICIDE CONTRACT

1. I ______________________________ agree not to kill myself, attempt to kill myself, or cause harm to myself during the next period of time from from ________________ to ________________, the time of my next appointment.

2. I agree to get enough sleep and eat well.

3. I agree to get rid of things I could use to kill myself–my guns and the pills.

4. I agree that if I have a bad time, and I feel I might hurt myself, I will call ________________ my counselor immediately at # ________________ or the Crisis Center (or Suicide Prevention Center) at # ________________.

5. I agree these conditions are part of my counseling contract with ________________.

Signed: ______________________________

Witnessed: ______________________________

Date: ______________________________

**Sample 7.** An example of a suicide contract. Based upon W.L. Getz, et al., in Fujimura, L.E., Weis, D.M., & Cochran, J.R. (1985). Suicide: Dynamics and implications for counseling. *Journal of Counseling and Development, 63* (p. 614).

presented in this section. Some professionally advised counseling techniques are also detailed. If the practicum student or intern has reason to suspect that his/her client is suicidal, he/she should immediately consult his/her supervisor rather than waiting until the next regularly scheduled supervisory session.

In order to facilitate the supervisory process, the *Practicum/Intern's Suicide Consultation Form* (Form 8.1) has been developed and can be found at the conclusion of this section. The practicum student or intern should fill out most of the form before the supervision conference and have the supervisor sign it at the conclusion of the session. The form is intended to help the student present the data germane to his/her client in an accurate and consistent manner. It also may aid in determining what the institutional policies are regarding practicum student or interns counseling suicidal clients. The practicum student or intern should keep a copy of the completed form in the clients' confidential records. This form provides documentation that appropriate ethical standards have been followed.

### References

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(Continued on p. 259)

# SUICIDE CONSULTATION FORM

**Directions:** Student will complete this form when working with potentially suicidal client. The student will take this information to his/her supervisor for consultation, collaborate on a treatment plan, and place in client's file.

**Part I**

Name of Institution: ______________________

Intern's Name: ______________________

Supervisor's Name: ______________________

Supervisor's Professional Degree: ______________________

Supervisor is liscensed in ______________________

Supervisor is certified in ______________________

Client's name: ______________________ Client's Age: ________

If the client is a minor, has the parent signed a consent form? ______________

When was the counseling initiated? Month ________ Day ________ Year ________

Where was counseling initiated? ______________________

Number of times you have seen this client ______________________

**Part II**

Check the presenting symptoms often associated with this suicidal client.

Client is between the age of 14 and 19. Yes ________ No ________

Client is depressed. Yes ________ No ________

If yes, include a description of the client's depressive behavior.

______________________

______________________

______________________

______________________

______________________

______________________

Has a previous attempt of suicide occurred? Yes ________ No ________

If yes, how long ago was the attempt? ______________________

Is the client abusing alcohol? Yes ________ No ________

If yes, how much does he/she drink? ______________________

______________________

Is the client abusing some other substance? Yes ________ No ________

If yes, what other substance? ________________________________________

________________________________________

Is rationale thinking lost? Yes? ________ No ________

If yes, explain how this behavior is manifested. ________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Does the client have little social support? Yes ________ No ________

How does the client spend his/her time? ________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Does the client have an organized plan. Yes ________ No ________

If yes, what is this plan? ________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

If a plan, does it seem irreversible, i.e., guns versus pills. Yes ________ No ________

Is the client divorced, widowed, or separated. Yes ________ No ________

Is the client physically sick? Yes ________ No ________

If yes, describe the symptoms. ________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Does the client have sleep disruption? Yes ______ No ______

If yes, describe the disruption. ______

Has the client given his/her possessions away? Yes ______ No ______

Does the client have a history of previous psychiatric treatment or hospitalization.

Yes ______ No ______

If yes, describe for what the client was hospitalized. ______

Does the client have any one near him/her to intervene? Yes ______ No ______

**Part III**

Describe and summarize your interactions with the client. What are his/her basic problems? What is your goal with the client? What techniques are you using.?

Describe your supervisor's reaction to the problem.

Supervisor's Signature

What are your plans for the client?

# SUICIDE CONSULTATION FORM

**Directions:** Student will complete this form when working with potentially suicidal client. The student will take this information to his/her supervisor for consultation, collaborate on a treatment plan, and place in client's file.

**Part I**

Name of Institution: ____________________

Intern's Name: ____________________

Supervisor's Name: ____________________

Supervisor's Professional Degree: ____________________

Supervisor is liscensed in ____________________

Supervisor is certified in ____________________

Client's name: ____________________ Client's Age: ________

If the client is a minor, has the parent signed a consent form? ____________________

When was the counseling initiated? Month ________ Day ________ Year ________

Where was counseling initiated? ____________________

Number of times you have seen this client ____________________

**Part II**

Check the presenting symptoms often associated with this suicidal client.

Client is between the age of 14 and 19. Yes ________ No ________

Client is depressed. Yes ________ No ________

If yes, include a description of the client's depressive behavior.

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Has a previous attempt of suicide occurred? Yes ________ No ________

If yes, how long ago was the attempt? ____________________

Is the client abusing alcohol? Yes ________ No ________

If yes, how much does he/she drink? ____________________

____________________________________________

Is the client abusing some other substance? Yes ________ No ________

If yes, what other substance? ________________________________________________

________________________________________________________________

Is rationale thinking lost? Yes? ____________ No ____________

If yes, explain how this behavior is manifested. ________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Does the client have little social support? Yes ____________ No ____________

How does the client spend his/her time? ________________________________________

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Does the client have an organized plan. Yes ____________ No ____________

If yes, what is this plan? ______________________________________________

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________________________________________________________________

________________________________________________________________

________________________________________________________________

If a plan, does it seem irreversible, i.e., guns versus pills. Yes ________ No ________

Is the client divorced, widowed, or separated. Yes ________ No ________

Is the client physically sick? Yes __________ No __________

If yes, describe the symptoms. ______________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Does the client have sleep disruption? Yes ______ No ______

If yes, describe the disruption. ______

Has the client given his/her possessions away? Yes ______ No ______

Does the client have a history of previous psychiatric treatment or hospitalization.
Yes ______ No ______

If yes, describe for what the client was hospitalized. ______

Does the client have any one near him/her to intervene? Yes ______ No ______

**Part III**

Describe and summarize your interactions with the client. What are his/her basic problems? What is your goal with the client? What techniques are you using.?

Describe your supervisor's reaction to the problem.

Supervisor's Signature

What are your plans for the client?

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# HARM TO OTHERS: A GUIDE FOR THE PRACTICUM STUDENT OR INTERN

Patrick B. Malley

Practicum students and interns should be aware that during the course of their training they may encounter clients who present a serious threat to other people. This counseling situation has ethical and legal implications for students as well as experienced counselors. Purposes of this section are to address these concerns and to offer guidelines to students should this problem occur while they are in training.

## THE TARASOFF CASE

Prosenjit Poddar was an outpatient at the University of California's Cowell Memorial Hospital. He informed his psychotherapist, Dr. Moore, that he planned to kill an unnamed girl, readily identifiable as Tatiana Tarasoff. Ms. Tarasoff was spending the summer in South America. In addition to this revelation the patient told Dr. Moore he was going to buy a gun. Dr. Moore consulted the psychiatric staff and determined that Poddar should be admitted to a mental institution for observation. The campus police were called who took Poddar into custody. After some period of detainment the campus police judged Poddar as rational and released him. At no point, did Dr. Moore, the police, or any other staff member of the clinic warn Tatiana or her parents about Poddar's expressed intentions of harmful behavior. On October 27, 1969, shortly after her return from Brazil, Tatiana Tarasoff was killed by Poddar in her place of residence (Crocker, 1985).

The Tarasoff parents attempted to sue the Regents of the University of California, the therapist involved, and the police. The case was initially dismissed by the trial court, and the court of appeal. Tatiana's parents persisted. They appealed to the Supreme Court of California, arguing that the defendants had a duty to confine Poddar under the provisions of California's Lantermon-Petris-Short civil commitment statute (Stone, 1976). This statute provides that

> When any person, as a result of mental disorder is a danger to others...a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him in a facility...for 72-hour treatment and evaluation. (p. 360)

In late 1974, the California Supreme Court decided that a cause for action for negligence did exist against both the therapist and the police for the "Failure to Warn" (Tarasoff, I).

The court apparently under pressure from various professional groups agreed to a rehearing. The court's final decision given on July 1, 1976, exempted the police from potential liability but held the plaintiff's suit could be amended to include the therapist alone. The plaintiff ultimately settled out of court. Consequently the court never found anybody libel. The court did set a standard for therapists, however

(Southard & Gross, 1982). The standard is as follows:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another he incurs a serious obligation to use reasonable care to protect the intended victim from such danger. (Tarasoff II, p. 43)

These two court cases have caused a great deal of confusion in the counseling profession. For example, Gehring (1982) stated:

> A counselor who is informed by a client that he intends to harm another could easily be held to a standard of knowing that the individual is a real threat to the well-being of another. Once such a disclosure is made and the counselor knows, or by the standards of his profession should know, that the client is serious, then the duty to warn could be applied assuming there is an identifiable victim... (p. 209)
>
> If the special relationship exists and there is a reasonable knowledge that a client's conduct may be harmful to another, then there is a legal duty to warn the intended victim where that victim is foreseeable. The concept of a duty to warn was initially applied in California but has since been adopted in several other jurisdictions. Failure to fulfill one's duty could result in liability for negligence. (p. 210)

Southard et al. (1982)* reported that the therapist does not have a "Duty to Warn" a potential victim:

> The language in Tarasoff II follows the typical pattern of tort law and relies on a flexible "duty of care," not on a rigid "duty to warn." As already noted, Sadoff (1979, p. 3) writes that Tarasoff established a "legal obligation to protect and warn third parties." This is dangerous because it increases the possibility that clinicians will seek to comply with Tarasoff by rigidly warning, not by seeking other ways of protecting the potential victim.
>
> The immediate questions that arises for a clinician is, what is meant by the phrase "reasonable care to protect the intended victim" (Tarasoff II, p. 431)? The court does not set down a rigid standard it recognizes that what is reasonable in one situation may not be reasonable in another. Also, it does not hold the therapist to a perfect standard as judged by the wisdom of hindsight. The court makes it very clear that, in some cases, a warning to the threatened party or some other particular action may be too radical a course to constitute "reasonable" care. In other cases, warning the victim may not be sufficient to fulfill the therapist's obligation.
>
> The fact that Tarasoff II does not simply mandate a warning in every case has been repeatedly emphasized here because it has so often been misunderstood to mean exactly that. With the true holdings of Tarasoff II firmly in mind, we cite two examples of such misunderstandings that involved quasi-official documents sent to agencies throughout the state of California to provide guidance on Tarasoff. The first is a memorandum by Carl Rauser, chief of the mental health program of the California Department of Health, addressed to all local mental health program chiefs. The memorandum begins: "The Supreme Court's decision of Tarasoff obligates psychotherapists to warn intended victims of serious threats of violence made by patients receiving treatment. A psychotherapist may be liable for damages in a civil suit if he knows of a threat but fails to warn the intended victim, and an assault occurs" (Rauser, 1977). The second document was addressed by the Office of Legal Affairs of Metropolitan State Hospital to its executive director (Office of Legal Affairs, 1980). This document quotes the Tarasoff rule as holding that a psychotherapist is "liable for failure to warn the victims of a patient who has confided an intent to commit violence." It is important to emphasize that both these statements, which were intended to guide therapists, are inaccurate. Tarasoff is very clear on the matter, and a later decision, Thompson, says flatly that therapists have "no general duty to warn" (Thompson v. County of Alameda, 1980, p. 371). (pp. 95-6)

In summary, the California Supreme Court set a standard for therapists when they have a client who expresses a "serious and imminent danger of violence" to others; however because two interventions were made by the court, one in 1974 and one in 1976, confusion was created in mental health professions.

Many professionals feel based on the initial court ruling that they have a "duty to warn" a potential victim. This is not true if one uses the second and final decision by the California Supreme Court, however therapists do have a duty to use "reasonable care to protect an intended victim." Warning the potential victim may be the appropriate course of action but is not necessarily the only one. Other alternatives to the "duty to warn" will be considered later in this section.

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## Ethical and Legal Implications of the Tarasoff Case

In order to fully understand the ethical and legal implications of the Tarasoff Case a brief look at the foundations of ethical and legal thinking regarding this matter are in order. A counseling relationship is defined by the law as a special or fiduciary relationship. This relationship carries with it legal and ethical implications. The practicum student or intern is bound by ethical codes (see Chapter 6) and the law to maintain confidentiality in this relationship. At the same time the ethical codes and the law agree that confidentiality may be broken if certain conditions exist. Presently, these conditions are (1) when the client presents a serious and imminent danger to himself/herself, (2) when the client presents a serious and imminent danger to others, and (3) when the client is abusing a child.

In regard to a client who is a serious and imminent danger to others much confusion still exists. *First, many are not sure what a serious and imminent danger to others is.* For instance, is a client who has bought a gun and a very clear threat to a specific victim the same as a client who has a serious cocaine addiction and is an air traffic controller with responsibility for the lives of hundreds of people? Is a driver of a school bus who confides to the counselor that he/she is a pedophiliac a serious threat to others? Second, if counselors decide that their client is going to seriously injure another or others what should they do? *What is reasonable care?* Should they warn the potential victim or victims? Is a client who reveals to the counselor that he/she is going to burn down his/her father's barn a serious threat to others? Consider for a moment the following scenario:

> You are counseling a young woman who is 17 years old. You have been counseling this woman for 5 months. Your sessions are twice a week for one hour each. During the process of therapy you can see this client is becoming increasingly anxious and hostile toward her mother. At some point in time your counselee tells you she is "mad enough at her mother to do her in." You ask her if she has a specific plan and how long she has had these thoughts. She responds that she has not had the thoughts for a long time, but they are becoming more intense. She does not yet have a well thought out plan. She has not yet acquired the weapon.

Now the question is what is "reasonable care?" Should the counselor break confidentiality and warn the mother? Should the counselor insist that the mother become part of the therapy sessions? Should the practicum student or intern do all of these things?

These decisions are very difficult ones for counselors/psychotherapists and would be exceedingly burdensome for practicum students or interns. Counselors are, on the one hand, ethically and legally responsible for maintaining a confidential therapeutic relationship and on the other hand legally responsible and accountable for using "reasonable care" to control the behavior of their clients. This section of your internship text will detail guidelines to help practicum students or interns focus their judgments regarding a client who is a serious threat to others. These guidelines can in no way be used as a panacea for this difficult problem. Many of the questions asked above can be answered only in a courtroom.

Southard et al. (1982) utilizing judicial clarifications of the Tarasoff Standard depicts a guide for action for a counselor when faced with clients who are potentially harmful to others.

### Judicial Clarifications of the Tarasoff Standard

by M.J. Southard and B.H. Gross

The therapist's legal duty can be better understood if we consider factors that influence the existence of a legal duty in general. The court in Thompson lists these as "the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost, and prevalence of insurance for the risk involved" (Thompson, 1980, p. 372).

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*Reprinted by permission of the publisher. Article appeared in B.H. Gross and L. Weinberger (Eds.), *The Mental Health Professional and the Legal System.* San Francisco: Jossey-Bass, December 1982.

These are the factors that the California Supreme Court took into consideration when it affirmed the existence of a duty based on the theory that a special relationship exists between the therapist and the patient. A later decision of the New Jersey State Court, Milano (McIntosh v Milano, 1979), has gone even further by saying that the existence of a duty to warn may also be based more broadly on a moral obligation to the welfare of the community analogous to the obligation that a physician has to warn a third person of infectious or contagious disease. It might, then, be useful to think of Tarasoff as establishing a legal duty that requires therapists to do what a responsible therapist would do anyway, namely, to take reasonable measures that protect confidentiality as much as is consistent with protecting endangered persons.

Several court decisions have clarified the application of Tarasoff to practical situations. Bellah v. Greenson (1977) involved a young woman who killed herself while under a doctor's care. The doctor had concluded that the young woman was in danger of committing suicide, and he had noted that fact in his records. Two years later, the young woman's parents sued the doctor for failing to warn them of her condition. The court said that the parents had no cause for action, since threats to self and property were not mentioned in Tarasoff. The court decliend to extend the holdings of Tarasoff to suicide and property damage, because confidentiality is the overriding concern in these cases.

In Thompson v County of Alameda (1980), a juvenile probationer who had threatened to kill an unnamed neighborhood child was nonetheless released on home leave. Immediately, he killed young Thompson, whose parents sued Alameda Count for releasing the juvenile probationer at all, for not exercising due care in not warning people in the style of Tarasoff, and for choosing the probationer's mother as custodian. The county was ruled immune from suit both for releasing the juvenile and for the choice of custodian. While the county was not immune from Tarasoff suits, the court ruled that its holdings did not apply to nonspecific threats made to nonspecified persons. Thus, for Tarasoff to apply, the victim must be identifiable, and the peril must be foreseeable.

Mavrodis v. Superior Court of County of San Mateo (1980) concerns a couple who were beaten by their son and who then sued to obtain his medical records from various psychiatric institutions to prove that they should have been warned. The court provided for an in camera review of the records, then ruled that "if a patient does not pose imminent threat of serious danger to readily identifiable victim, a disclosure of patient's confidence would not be necessary to avert threatened danger, and therapist would be under no duty to make such disclosure" (Mavrodis, 1980, p. 725). Imminence of danger is therefore necessary for the Tarasoff duty to exist.

These clarifications are included in the factors weighed in the decision chart (Diagram I). This decision chart will be of great assistance in helping therapists deal with their professional duty to protect persons threatened with harm by clients whom they are treating. The decision chart considers in an ordered, schematic fashion the various elements that go into a decision about how to handle cases in which a client threatens to harm another person.

**A Guide For Action**

The critical issues and options facing clinicians as a result of Tarasoff can be identified in the decision chart. The clinician can use the chart to organize his/her thinking by following the chart from Step A to Step G.

The issues depicted in the chart *in Diagram I* arise when a client who comes under the protection of confidentiality poses a threat of serious harm to a third party. Note that threats of suicide or threats of destruction of property do not warrant consideration under Tarasoff, because in these cases the client's right to confidentiality is presumed to outweigh the potential danger.

> Step A. Here, the chart calls for the therapist to distinguish between clear threats of harm and vague threats of harm. A vague threat is something like: "If this keeps up, I might do something bad to my mother." In such cases, the clinician must make reasonable inquiry to clarify the client's meaning, but need not conduct an interrogation. A degree of clinical skill and common sense is called for at this point, because the clinician can be held liable for making "a reasonable decision according to the standards of the profession" (Tarasoff II, p. 431) about whether the threat was in fact clear.
>
> Step B. If the threat is seen as clear, the clinician proceeds to Step B. Clinical judgment again comes into play, since the mental health professional must decide whether the threat already determined to be clearly expressed presents only a marginal danger (for example, because the threat itself is frivolous or because of the person making the threat), or whether it presents a serious and actual danger. If the therapist determines that serious danger exists and

the therapist works in an agency, the appropriate clinical supervisor must be contacted and the treatment plan must be reviewed according to standard agency procedures. A therapist in private practice should seek consultation from a colleague and establish ample documentation to buttress his legal position. Clinicians need to remember that they will be judged against "the standards of the profession" (Tarasoff II, p. 431) if it has to be determined whether they ought to have uncovered the existence of a serious danger.

It is important, however, for therapists not to jump the gun and prematurely decide that action should be taken that infringes either on the client's confidentiality or on other best interests. Ironically, the Tarasoff case itself is a clear example of rash intervention, since the threatened danger to Tatiana was not imminent (See Step D), in that she was outside the country when the threats were made. Nevertheless, Podar's therapists called upon the police to have him committed. Unnecessarily, they destroyed the therapeutic alliance. Perhaps they even placed Tatiana in greater peril than she had been before their intervention (Sadoff, 1979, p. 3).

Step C. Now the clinician considers whether there is an identifiable potential victim of the serious danger threatened. If the clinician cannot identify a specific victim as seriously threatened, the clinician is under obligation to make a reasonable inquiry. When a specific victim has been named—or when the specific victim is able to be discovered "upon a moment's reflection" (Tarasoff II, p. 439)—the clinician proceeds to Step D. But if, after inquiry, there is still no identifiable victim, the therapist, as Thompson makes clear, has no Tarasoff obligations. Careful treatment should continue. However, prudence requires the clinician to document his reasons for deciding that the victim is not identifiable.

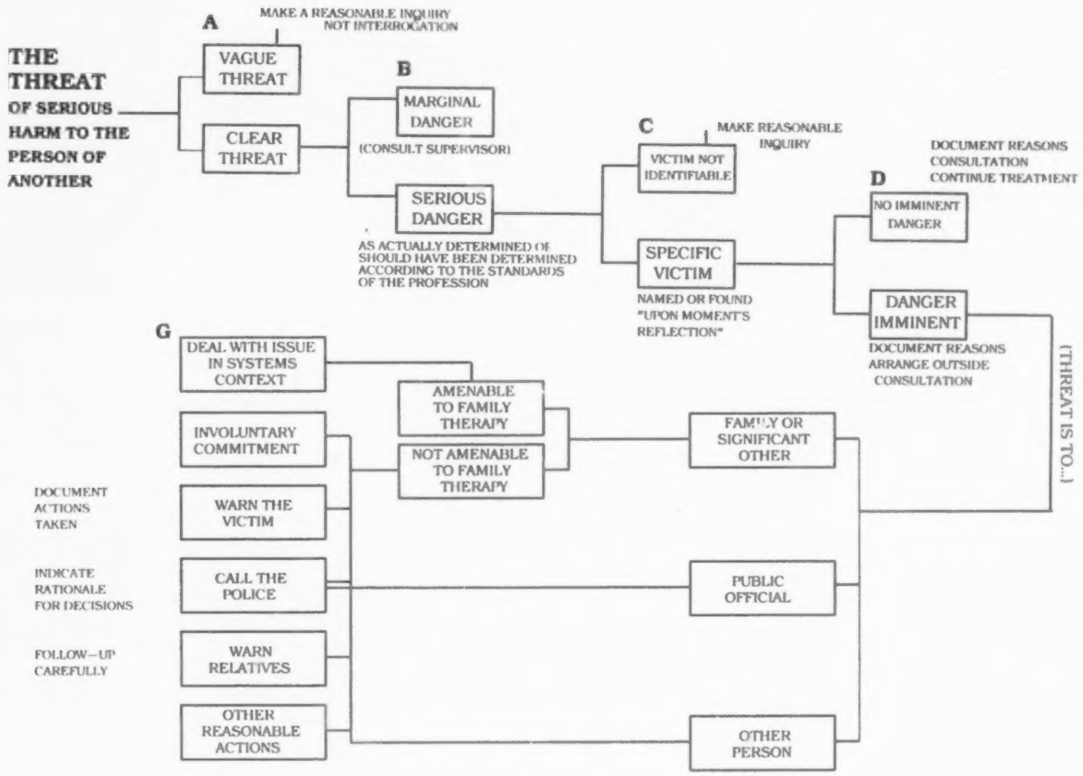
Step D. The decision involved in Step D concerns the imminence of the serious danger to an identifiable person. If the threat of danger is serious but not imminent, the reasons why no imminent danger is seen must be documented in the client's record. The treatment plan can be aimed at reducing the client's potential for violence, and it can be reviewed for progress by a clinical supervisor or colleague. If the clinician determines after consultation that the danger is imminent, he proceeds with the documentation and treatment but also continues on to Step E.

Step E. Here, the person threatened is distinguished as a member of one of three different groups: family members or significant others, public officials, and all other persons. If a public official is threatened seriously and imminently with harm, there are no further decisions to be made. The police must be contacted immediately. If a member or a significant other, such as a long-term lover, is threatened, then the clinician proceeds to step F. If the threat is to any other person, then the clinician skips step F and proceeds to step G.

Step F. In this step, the therapist determines whether the client and the familial victim are amenable to treatment within the context of family therapy. If the case is amenable to family therapy, then the potential for violence (and also the warning to the threatened person) can be dealt with in the framework of the system that presumably evokes the violent response. Wexler (1979) makes a strong case for the utility of this approach. However, if the clear, serious threat of imminent harm is made not to a public official or a family member but to some other specific person, or if the threat to the family member occurs in a case that is not amenable to family therapy, the clinician proceeds to Step G.

Step G. This step provides several options. The therapist can have the client involuntarily committed to a mental institution as "dangerous to others" if the proper criteria are met. The clinician can warn the victim, warn the relatives of the victim, call the police—in any combination. Indeed, the clinician may be obligated to do one or all of these things, depending on what seems to provide reasonable care for the safety of the person threatened. The clinician can also take any other actions that seem reasonable, separately or in combination with the options already mentioned. In any case, care must be taken to document the actions that are taken, including the rationale for the choices made. The rationale is important, because the therapists are held to a standard of reasonable care, not to a standard of successful performance. Whatever choice the therapist makes in step G, it is important for the therapist to follow up on the results of the choice, both for the client and for the potential victim.

# TARASOFF DECISION CHART


THE THREAT OF SERIOUS HARM TO THE PERSON OF ANOTHER
A
MAKE A REASONABLE INQUIRY NOT INTERROGATION
VAGUE THREAT
CLEAR THREAT
B
MARGINAL DANGER
(CONSULT SUPERVISOR)
SERIOUS DANGER
AS ACTUALLY DETERMINED OR SHOULD HAVE BEEN DETERMINED ACCORDING TO THE STANDARDS OF THE PROFESSION
C
MAKE REASONABLE INQUIRY
VICTIM NOT IDENTIFIABLE
SPECIFIC VICTIM
NAMED OR FOUND "UPON MOMENT'S REFLECTION"
D
DOCUMENT REASONS CONSULTATION CONTINUE TREATMENT
NO IMMINENT DANGER
DANGER IMMINENT
DOCUMENT REASONS ARRANGE OUTSIDE CONSULTATION
(THREAT IS TO...)
FAMILY OR SIGNIFICANT OTHER
PUBLIC OFFICIAL
OTHER PERSON
AMENABLE TO FAMILY THERAPY
NOT AMENABLE TO FAMILY THERAPY
G
DEAL WITH ISSUE IN SYSTEMS CONTEXT
INVOLUNTARY COMMITMENT
WARN THE VICTIM
CALL THE POLICE
WARN RELATIVES
OTHER REASONABLE ACTIONS
DOCUMENT ACTIONS TAKEN
INDICATE RATIONALE FOR DECISIONS
FOLLOW-UP CAREFULLY

> To summarize, Tarasoff does not impose a duty to warn. It requires the therapists to respond to clear, serious threats of imminent harm to specific identifiable persons in a manner that uses reasonable care to protect the intended victim against such danger. The decision chart will be of great use in helping the therapist decide whether a Tarasoff situation exists and, if it does, what the options for handling it are. Tarasoff puts mental health professionals in a position to make decisions that are very difficult, but, by using the chart and a little common sense, therapists can both protect their own legal position and ensure that their clients receive care and treatment that protect not only their best interests but the safety of others as well. (p. 93-101)

Appelbaum (1985) presented a model for fulfilling the Tarasoff obligation. He reported that decisions that have relied on it as a precedent appear to require clinicians treating potentially dangerous patients to undertake a three-stage process of assessment, selection of a course of action, and implementation. The *first stage, assessment,* has two components: (a) therapists must gather those data relevant to an evaluation of dangerousness, and (b) a determination of dangerousness must be made on the basis of those data. The *second stage* of the process asks that the clinician who has determined that a patient is likely to be dangerous *select a course of action* to protect potential victims. The *third stage* of the model requires therapists to *implement* their decisions appropriately. This requirement has two components. (a) the means chosen to protect victims must be carried out effectively and (b) the situation must be monitored on a continuing basis to access the success or failure of the initial response, the likelihood that the patient will be violent and the need for further measures to decrease the risk presented by the patient.

### Problems with Models and Harm to Others

Practicum students and interns should utilize models presented in this section. As noted previously, the models should not be construed as panaceas for the problem. Court decisions are not always unanimous and judicial thinking does not always honor precedent. The following represents some illustrations of this point.

In McIntosh v Milano (1979) a New Jersey case, Lee Morgenstein, an adolescent boy, referred by a school counselor, told his therapist he wanted to have sex with the girl next door. Her name was Kimberly. He had shot a BB gun at her car when she left for a date. He also showed a knife to his therapist and said that he wanted to see Kimberly suffer. The therapist never warned Kimberly or her parents. Ultimately the boy killed Kimberly. Obviously a clear threat was never made by the boy against the victim and one could reasonably argue that an imminent danger never existed. Nevertheless, the case was taken to court claiming the Tarasoff Case as precedent. Dr. Milano, the therapist, was found not negligent.

In Thompson v County of Alameda (1980) Judge Tobriner joined by Mosk wrote:

> Our opinion in Tarasoff makes clear that failure to warn a victim who is identifiable does not constitute an essential element of the cause of action. We noted that the duty of care requires the defendant "to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances...
>
> At no point did we hold that such a duty of care runs only to identifiable victims. We cited numerous examples to the contrary.
>
> One example makes the point particularly clear: "(a) doctor must warn a patient if the patient's condition or medication renders certain conduct such as driving a car, dangerous to others. (614 P2d 728-739)"

In Bellah v Greenson (1977) the California Appellate Court held that a psychiatrist could not be held libel for failure to warn the parents of a deceased patient, who committed suicide. The court refused to extend the holding of Tarasoff and clearly asserted that there was no duty to warn others of self-inflicted harm or the *likelihood of property damage.*

Stone (1986) reported, however, that Tarasoff now extends to include a duty to protect third parties against property damage, as a result of the following case.

John Peck, a 29 year old "patient-client" of the Counseling Service of Addison County in Vermont had been seeing a therapist, who had an MA in educational psychology and a certificate as a psychological counselor. Mr. Peck had been active in therapy from September 1976 to October 1977. Between October 1977 and June 1979, Mr. Peck was not active in therapy, but had been placed in a vocational workshop. After an altercation at his boarding house in which Mr. Peck physically assaulted another resident he left the vocational workshop and returned to counseling. Mr. Peck resumed therapy on June 1, 1979. After an argument with his father Mr. Peck told his therapist on June 21, 1979 that he wanted to get back at his father. When his therapist inquired how he intended to do this, Peck stated "I don't know; I could burn down his barn." At this point the therapist explored the consequences of this proposed behavior and "secured a verbal promise not to burn down his father's barn." The therapist made a judgment, based on her professional expertise and knowledge of the client, that Mr. Peck would keep his verbal promise and not act out his threat. The therapist thus did not warn Mr. Peck's family or consult with any other staff member concerning this threat. On June 27, 1979, John Peck acted out his threatened behavior and burned down the family barn which housed animals. The barn was 130 feet from the family home where his parents were residing. The parents sued the Counseling Service of Addison County for damages incurred by the property loss. The parents claimed that the counseling services was negligent because the therapist did not warn them of the potential harm threatened by their son. Under Vermont law there was no legal duty for a warning to be given. However, the case was appealed to the Vermont Supreme Court which consequently created that duty, "We hold that a mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger."

In Lipari v Sears, Roebuck and Company (1980) the United States District Court determined that if faced with the question, the Nebraska Supreme Court would adopt the reasoning of Tarasoff. In this case the client was an outpatient at the VA treatment center. He purchased a gun from Sears, and later fired into an open room. Two people were killed. Even though the identity of the victims was remote the court ruled that action should have been taken. This case essentially expanded the ruling in the Thompson decision, and now unidentifiable victims fall within the domain of the Tarasoff Case.

## Guidelines for Practicum Students and Interns Regarding Harm to Others

Students in training should know that when a client is determined to pose a dangerous and imminent threat to another's well being serious legal and ethical questions are at issue. Probably many agencies or schools do not have an explicit policy regarding this situation. The practicum student or intern should pay close attention to the material presented in this section of the manual and immediately consult the site supervisor regarding a violent client. To defer the supervision until a regularly scheduled conference is due would not be advisable because the institutionalized supervisory conference could be seen as scheduled out of convenience rather than the client's special needs showing that supervision was considered after careful evaluation of what the client needs.

The supervisor is seen in the eyes of the law as acting under the auspices of *respondent superior* (literally, "let the master answer"). This is a form of vicarious liability in which an employer or supervisor is held liable for the wrongful acts of an employee or supervisee. The assumption is that the master or site supervisor is responsible for those negligent acts of his/her agent that takes place during the agent's employment or training (Snider, 1985).

To expedite the supervisory process, a form entitled *Harm to Others* (Form 8.2) has been developed. It can be found at the end of this section. Utilizing this form, the practicum student or intern can systematically list the reasons why he/she believes the client to be potentially dangerous. The practicum student or intern should fill out most of the form before the supervisory session. The supervisor's advice or reactions should be recorded at the conclusion of the conference. At that time the supervisor should sign the form. The practicum student or intern should keep a copy of the completed form in his/her confidential records. This form serves as documentation that appropriate ethical/legal standards have been followed.

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# HARM TO OTHERS

**DIRECTIONS:** Student completes the form prior to supervisory sessions, records supervisor's comments and reactions, and have the student and supervisor sign the completed form. The student should keep the form in his/her confidential records.

1. Student's Name:
   Client's Name:

2. Number of times the client has been seen:

3. Dates client has been seen:

4. Client's presenting problem:

5. Type of therapy given:

6. What did the client do or say to make the counselor concerned that he/she could represent "harm to others?":

7. Was a specific victim(s) named?:

8. If the victim was named, what was the relationship of the client to the victim?

9. If the victim was not named, did the counselor suspect who the person was?:

10. Was a clear threat made?:

11. Is serious danger present?: ____

12. Is the danger believed to be imminent?: ____

If so, Why?: ____

If no, Why?: ____

13. Supervisor's reaction/advice?: ____

14. What plan of action is to be taken?: ____

Student's Signature

Supervisor's Signature

Date of Conference

*Tarasoff II*, vacating 13 Cal. 3rd. 117, 529 P. 2d. 553, 118, Cal. Rptr. 129. (1974) (Tarasoff. I).

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## SUBSTANCE ABUSE

Concerns and problems related to tobacco, alcohol, and drug use and abuse are common occurrences in any population of individuals seeking counseling. What makes counseling difficult regarding these concerns is the role of such substances in our society. Tobacco and alcohol are the two most commonly accepted and used drugs in the United States today. As young people enter the teenage years, nearly all try smoking and drinking. Large proportions of those who experiment with either go on to become regular social users as adults. Furthermore, many who use one of these use the other.

Experimentation with marijuana is common. Use and abuse of other illicit drugs have increased, especially cocaine and crack. Prescription drugs, such as valium and diet medications, are readily available and used. Use of designer drugs is on the increase.

Over-the-counter drugs are advertised as the solution to any ache, pain, or problem. Tobacco, beer, and wine are widely promoted.

The job of a counselor would in fact be much easier if all people who had drug and alcohol concerns and problems were able to identify them and seek help. Recent attention to problems of substance use in society has heightened awareness and public discussion. More people are sensitive to the role and consequences of their personal substance use and seek out someone with whom to talk about it. However, many people continue for years to struggle without recognizing their problems.

Practicum students and interns should learn the typical symptoms a client exhibits who is abusing a substance and what techniques should be utilized for counseling. Students also should avail themselves of appropriate referral procedures and their agency's policy on substance abuse. Students should learn their site's rules and regulations and Federal Laws as they relate to confidentiality and substance abuse. Finally all students should actively seek supervision and adhere to and know their agency's policies on these matters.

## SUBSTANCE ABUSE*

### Facts About Substance Abuse

A. It is a disease with formal recognition by the A.M.A. in 1956.

B. Substance abuse is the overwhelming urge to use regardless of the consequences. As the illness progresses it produces a negative impact in all areas of the affected person's life.

C. It affects 1 out of 10 adults and 1 out of 5 adolescents.

D It is not a respecter of social, cultural, ethnic, economic, or religious boundaries.

E. It is the largest neglected health problem in America.

F. It is the 3rd largest cause of death preceded by cancer and heart disease.

### Symptoms of Substance Abuse—Alcoholism

A. Signs of alcoholism
    1. Growing preoccupation
        a. Anticipation of drinking
            1). During daytime activities
            2). Vacation times (fishing trips become drinking binges)
            3). Growing involvement in drinking activities (bar building, receipts)
        b. Growing need during times of stress
            1). On the job
            2). Family and marriage problems
            3). Emergencies
            4). Important decisions

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B. Growing rigidity in life-style

1. Particular times for drinking during the day
2. Will not tolerate interference during drinking times
3. Limits "social" activities to those which involve drinking.

C. Growing tolerance

1. Ability to drink more
2. Ingenuity around obtaining the chemical without others being aware
    a. Gulping drinks
    b. Ordering "stiffer" drinks (doubles, martinis, etc.)
    c. Self-appointed bartender at social gatherings
    d. Sneaking drinks
    e. Drinking prior to social engagements
    f. Purchasing liquor in greater quantities (cases of six-packs)
    g. Protecting supply
3. Purchasing more well before current supply is exhausted.
4. Hidden bottles (at home, car, on the job)

D. Loss of Control

1. Increasing blackouts
2. Drinking a larger quantity than planned
3. Binge drinking
4. Morning drinking
5. Repeated harmful consequences resulting from chemical use
    a. Family
        1). Broken promises involving "cutting down"
        2). Drinking during family rituals (Christmas, birthdays)
        3). Sacrificing other family financial needs for chemicals
        4). Fights (physical), arguments about drug usage
    b. Legal
        1). Traffic violations (D.W.I., etc.)
        2). Drunk and disorderly
        3). Lawsuits caused by alcoholic impaired judgment
    c. Social
        1). Loss of friendship because of antisocial behavior
        2). Previous hobbies interests and community activities neglected as a result of increased chemical use
    d. Occupational
        1). Absenteeism (hangovers)
        2). Lost promotions due to poor performance
        3). Threats of termination
        4). Loss of job
    e. Physical
        1). Numerous hospitalizations
        2). Medical advice to cut down
        3). Using alcohol as medication
            a). To get to sleep
            b). To relieve stress
    f. Growing defensiveness
        1). Vague and evasive answers
        2). Inappropriate affect around consequences of drug usage
        3). Frequent attempt at switching to other areas of concern.

## Symptoms of Substance Abuse—Drug Dependency

A. Signs of drug dependency

1. Growing preoccupation
    a. Anticipation of drug usage
        1). Keeping track of prescribed times for dosage
        2). Growing number of physical complaints which would require more drugs to relieve them
    b. Growing need during times to prevent stress
        1). Begins to attempt to prevent stress
        2). Emergency situations

B. Growing rigidity in life-style

1. Has particular times during day for drug usage, e.g., can't sleep unless he/she takes a sleeping pill
2. Cannot go anywhere without supply of medication
3. Will resent attempt made by others to limit drug intake

C. Growing tolerance

1. Increasing dosage and/or number of different medications
2. Ingenuity around obtaining the drug without others being aware
    a. Seeking out a variety of physicians and dentists for prescriptions but not informing them about each other
    b. Attempting to get refillable prescriptions

c. Use of several drugstores
d. Using several drugs in combination for the synergistic effect, e.g., a barbituate and alcoholic drink
e. Using the drug for longer time period than the original prescription specified
f. Protecting the supply
  1). Purchasing more before current supply is exhausted

D. Loss of control

1. Increasing blackouts and memory distortion
2. Larger and more frequent dosages than prescription calls for—using another person's prescriptions
3. Continuous dosages, e.g., red pill every three hours, white pill every two hours, green capsule twice daily, etc.
4. Repeated harmful consequences resulting from drug usage
  a. Family
    1). Frequent blackouts which lead to many "broken commitments"
    2). Inappropriate behavior during family rituals (Christmas, birthdays)
    3). Sacrificing other family needs for doctor appointments and prescriptions
    4). Changing family duties due to physical incapacity (increased time in bed, lack of motivation and drive
  b. Legal
    1). Buying and/or selling illegal drugs
    2). Buying from illegal sources
    3). Traffic violations
    4). Disorderly conduct violations
  c. Social
    1). Loss of friendship because of past antisocial behavior
    2). Previous hobbies, interests, and community activities neglected as a result of increased drug usage
  d. Occupational
    1). Absenteeism
    2). Lost promotions due to poor performance
    3). Demotions due to impaired and inappropriate behavior
    4). Loss of job
  e. Physical
    1). Numerous hospitalizations
    2). Increasing number of physical complaints
    3). Physical deterioration due to chemical use
  f. Growing defensiveness
    1). Vague and evasive answers
    2). Inappropriate affect around consequences of drug usage
    3). Frequent attempts at switching to other areas of concern

## Treatment Approaches

The client who is abusing a substance can be helped by utilizing the services of a counselor. Practicum students and interns should learn the counseling techniques that have proved to be the most successful relative to substance abuse. Some of these techniques are as follows

**Face the substance abuse.** In a caring, helpful way, confront the client directly with the reality of his/her behavior.

**Confront the substance abuser.** Present specifics of behavior and avoid discussing or exploring reasons for abusing. Provide the client with information about his/her abuse and behavior when abusing. The client will try to avoid this, deny it, and skillfully change the subject. The patient will offer many reasons for abusing. Avoid discussing these reasons because doing so takes the focus off the abuse problem.

**Be consistent, firm, yet caring.** Stick with it; do not give up on the client. The client will try to manipulate you. Continue to point out the discrepancy between what is said and actions of the abuser. Point out the reality of what is happening because of the abusing.

**Be nonjudgmental.** Provide the information in an objective way. Preaching or moralizing about the abuse are useless approaches. The client needs to know you respect his/her decisions about abusing. Your role is to provide information about the illness so that the decision can be made.

**Limit empathy.** While letting the patient know you understand how he/she feels, encourage the patient to think to the future. Attempt to build on the strength of the abusing client—and everyone has some strengths.

**Listen.** At times you may be the only person who has ever been willing to listen to the abuser. Listen in a caring, concerned, interested, and respectful manner.

**Be calm and supportive.** Because the abuser is ridden with guilt and must therefore deny abusing, he/she may often express anger towards others. If you remain calm, the effect on the patient may be calming. If you are supportive, you will be able to lessen his/her overwhelming fear.

**Do not give up.** The client may take a long time to accept the fact that he/she has an abuse problem and needs help. Your role is to continue to get the client ready by consistent and caring confrontation. The recovering patient may have relapses. The course of any illness is rarely one of steady improvement. Continue to guide the patient toward recovery.

By the preceeding approach, you are helping to weaken the abuser's *denial defense* which prevents him/her from getting treatment for the abusive behavior.

In addition to these treatment approaches, the student may want to use the *Substance Abuse Assessment Form* (Form 8.3) to gather information regarding his/her client's abusive behavior. Form 8.3 may be found at the end of this section.

## THE REFERRAL PROCESS

If the practicum student or intern decides his/her client has a serious problem related to substance abuse, he/she should immediately consult his/her supervisor. Through this process it may be determined that the client should be referred to an agency that specializes in substance abuse. In the following are listed some recommended guidelines for the referral process:

- Tell the client and/or family about the kinds of helping resources available to them. Give examples. "We know that abuse is a problem to many individuals and many families. Anyone wanting help can get it."
- Offer to make the initial call to the resource agency to let them know the client will be calling.
- Get back to the client to tell him/her the call has been made and the agency is expecting a call. Give the client the name of a particular person to contact if that is the arrangement with the agency resource. Give the client the name and telephone number of the agency.
- Set a day by which the call should be made—this week. Let the client know you will check back with him/her to see what happened.

### Purpose and Use of the Substance Abuse Assessment Form

*A Substance Abuse Assessment Form* (Form 8.3) can be found in the last part of this section. As previously mentioned, this form may be used in connection with the treatment approach. This form is a valuable tool because the referral agency may ask the practicum student or intern about the client and the behavior clues he/she observed about the client's abuse. This may help the agency in its assessment of the problem. More specifically, it may aid the agency in the following areas:

1. to predict problems,
2. to determine the stage of illness,
3. to evaluate treatment needs,
4. to determine immediate health needs,
5. to detect possible dual addiction problems,
6. to predict potential withdrawal problems,
7. to evaluate treatment needs, and
8. to predict possible psychiatric problems.

Practicum students and interns should ask their clients the questions contained in the *Substance Abuse Assessment Form.* They

(Continued on page 281.)

# SUBSTANCE ABUSE ASSESSMENT FORM

**Directions:** Student asks the client the specific questions addressed on the form. Student, client, and supervisor should sign the form. The completed form is kept in the student's confidential file.

1. What do you or have you used? ______

2. How long have you used (beginning from experimentation)? ______

3. How often are you high in a week? ______

4. How many of your friends use? ______

5. Are you on medication? ______

6. Do you owe money for chemicals? How much? ______

7. How much do you spend for chemicals in a month (if you were to pay for all the chemicals)? ______

8. Who provides if you are broke? ______

9. Have you ever been busted (police, school, home, DWI's)? ______

10. Have you lost a job because of your use? ______

11. What time of day do you use? ______

12. Do you use on the job or in school? ______

13. Does it take more, less, about the same amount to get you high? ______

14. Have you ever shot up? What? Where on your body? ______

15. Do you sneak using? How do you do it? ______

16. Do you hide stuff? ______

17. Do you have rules for using? What are they? How did they come about? ______

18. Do you use alone? ______

19. Have you ever tried to quit? ______

20. Have you had any withdrawal symptoms? ______

21. Have you lost your "good time highs?"

22. Have you ever thought about suicide?

23. Do you mix your chemicals when using?

24. Do you ever shift from one chemical to another? Yes No
What happened that made you decide to shift?

25. Do you avoid people who don't use?

26. Do you avoid talking about chemical dependency?

27. Have you done things you are ashamed of when using? Yes No
What happened?

28. Who is the most important person in your life, including yourself?

29. How are you taking care of him/her?

30. On a scale of 1 (low) to 10 (can't use 5) how is your life going?
Explain

31. Are there any harmful consequences you are aware of in your chemical use other than those touched upon? ______

32. Do you think your chemical is harmful to you? Yes ______ No ______
Do you think you have a chemical problem? Yes ______ No ______
Explain ______

______
Student's Signature

______
Client's Signature

______
Supervisor's Signature

______
Date

## CONSENT FORM

I ______ give permission to ______,
Client's Name — Practicum/Intern Student

his/her supervisor ______, and the agency for which they function
Supervisor's Name

______ to forward the information regarding my substance abuse
Agency's Name

issues, contained in the Substance Abuse Assessment Form 8.3 to ______.
Substance Abuse Agency

This information must be kept confidential and may **not** be forwarded to any other agency without my permission.

______ ______
Date — Client's Signature

# SUBSTANCE ABUSE ASSESSMENT FORM

**Directions:** Student asks the client the specific questions addressed on the form. Student, client, and supervisor should sign the form. The completed form is kept in the student's confidential file.

1. What do you or have you used?
2. How long have you used (beginning from experimentation)?
3. How often are you high in a week?
4. How many of your friends use?
5. Are you on medication?
6. Do you owe money for chemicals? How much?
7. How much do you spend for chemicals in a month (if you were to pay for all the chemicals)?
8. Who provides if you are broke?
9. Have you ever been busted (police, school, home, DWI's)?
10. Have you lost a job because of your use?

11. What time of day do you use?

12. Do you use on the job or in school?

13. Does it take more, less, about the same amount to get you high?

14. Have you ever shot up? What? Where on your body?

15. Do you sneak using? How do you do it?

16. Do you hide stuff?

17. Do you have rules for using? What are they? How did they come about?

18. Do you use alone?

19. Have you ever tried to quit?

20. Have you had any withdrawal symptoms?

21. Have you lost your "good time highs?" ____

22. Have you ever thought about suicide? ____

23. Do you mix your chemicals when using? ____

24. Do you ever shift from one chemical to another? Yes ____ No ____
What happened that made you decide to shift? ____

25. Do you avoid people who don't use? ____

26. Do you avoid talking about chemical dependency? ____

27. Have you done things you are ashamed of when using? Yes ____ No ____
What happened? ____

28. Who is the most important person in your life, including yourself? ____

29. How are you taking care of him/her? ____

30. On a scale of 1 (low) to 10 (can't use 5) how is your life going? ____
Explain ____

31. Are there any harmful consequences you are aware of in your chemical use other than those touched upon? ______

32. Do you think your chemical is harmful to you? Yes ______ No ______
Do you think you have a chemical problem? Yes ______ No ______
Explain ______

______
Student's Signature

______
Client's Signature

______
Supervisor's Signature

______
Date

## CONSENT FORM

I ______ give permission to ______,
Client's Name — Practicum/Intern Student

his/her supervisor ______, and the agency for which they function
Supervisor's Name

______ to forward the information regarding my substance abuse
Agency's Name

issues, contained in the Substance Abuse Assessment Form 8.3 to ______.
Substance Abuse Agency

This information must be kept confidential and may **not** be forwarded to any other agency without my permission.

______ ______
Date — Client's Signature

should note the answers to these questions on the form. When the session is over, the client and the supervisor should also sign the form when it is appropriate. The form should be kept in the practicum student's or intern's confidential files until the agency requests it. The form cannot be sent to the agency without the client's written consent. The *Consent Form* (Form 8.4) should be used for this purpose. The Consent Form can be found within this section. Form 8.4 must be utilized in this situation. Practicum students and interns not only are ethically responsible to enforce confidentiality in these matters but also are legally bound to adhere to both state and federal laws which address confidentiality and substance abuse counseling. Students should learn their appropriate state law on confidentiality and substance abuse.

* * *

## CHILD ABUSE AND NEGLECT: A GUIDE FOR PRACTICUM STUDENTS AND INTERNS

Lou Ann Schrock-Brutz and Patrick B. Malley

In dealing with the issue of child abuse and/or neglect in clinical settings, student counselors must bear in mind the unique relationship they have with their field supervisors, the responsibility they have to the institution at which they are working, and the clients they serve. A close working relationship with the field site supervisor is imperative to the learning process and to insure that proper and quality care is afforded to clients.

In all instances regarding child abuse, an immediate report should be made to the field site supervisor and a review of the institution's policy should be completed. The following guide is just that, and should only be utilized in conjunction with the institution's policy and at the discretion of the field supervisor.

### Definition

Child abuse legislation first appeared around the turn of the century in New York State. Compared to present day statutes it was quite vague and weak (Guyer, 1982). Currently all fifty states have enacted child abuse laws requiring mandatory reporting. The laws in some states remain vague and allow for a degree of variation in judicial and regulatory responses. This is also true of the confidentiality issues involved in mandatory reporting (Erickson, McEvoy, & Colucci, 1984). Therefore, the student counselor will need to be familiar with the particular legislation in the state where he/she is completing the field study.

For purposes of this article, the Pennsylvania "Child Protective Services Law" Act of 1975, P.L. 438, No. 124 was utilized in conjunction with Act 136 of 1982 and Act 42 of 1983. This Act defines child abuse and neglect in Section 3 as follows:

> As used in this act: "Child abuse" means serious physical or mental injury which is not explained by the available medical history as being accidental, or sexual abuse or sexual exploitation, or serious physical neglect, of a child under 18 years of age, of the injury, abuse or neglect has been caused by the acts or omissions of the child's parents or by a person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of a child's parent provided, however, no child shall be deemed to be physically or mentally abused for the sole reason he is in good faith being furnished treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof or is not provided specified medical treatment in the practice of religious beliefs, or solely on the grounds of environmental factors which are beyond the control of the person responsible for the child's welfare such as inadequate housing, furnishing, income, clothing and medical care.(p.1)

### Recognition

Child abuse and/or neglect becomes apparent to the counselor in one of two ways: either by direct verbal report or by being uncovered indirectly via the counseling process. When uncovered directly via report either the victim, perpetrator, or some other party involved with the victim or perpetrator reports such. This is the most direct method and the position of the counselor is not to evaluate the authenticity of the report, at least not at this phase. This is the job of the children and youth authorities.

What about when the counselor is not told directly but suspects absue and/or neglect may be occurring? Erickson, McEvoy, and Colucci (1984) referred to some general "characteristics" of child abuse applicable to the victim and perpetrator. Of these, the most widely accepted for the abuse and/or neglectful parent are as follows:

1. abused as children themselves,
2. socially and emotionally immature,
3. low self-esteem,
4. expect children to act as adults,
5. cannot express frustration or anger via acceptable behaviors,
6. expectations of their children are not realistic given their ages,
7. violent marital discord,
8. abuse of drugs and/or alcohol,
9. inability to tolerate stress,
10. lack adequate parenting skills,
11. ignore child's needs,
12. are guarded in discussing family relationships, and
13. lack of an appropriate role model.

The most widely accepted general characteristics of the abused and/or neglected child are as follows:

1. inappropriate hostility directed toward authority figures;
2. disruptive and destructive;
3. passive and withdrawn, crying easily;
4. fearful at times, not wanting to go home (or to the place where abuse occurs);
5. habitual absence or tardiness from school;
6. inappropriately dressed for the weather;
7. failure to thrive symptoms;
8. bruises, burns, or other unexplainable marks;
9. chronically untreated medical needs;
10. constant hunger
11. sexually oriented remarks;
12. sexually suggestive behavior;
13. discomfort of genital areas; and
14. according to Buckner (1985), significant differences from the mean for anxiety levels.

One must exercise caution in evaluating these "general characteristics." The counselor needs to be concerned when several of the characteristics of the abusive parent and abused child are present. The presence of only a few characteristics may only be indicative of a dysfunctional family. In observing these characteristics, keep documented records for specifically addressing these issues for future reference.

## Reporting

The "Child Protective Services Law," Section 4 (a-d), deals with mandatory reporting of suspected child abuse. The one in Pennsylvania is representative of those in other states. This section specifies that any person who, in the course of their professional occupation, has reason to believe that a child coming before them is a victim of suspected child abuse must report this to the appropriate children and youth agency. The local county office numbers can be obtained by contracting the hotline office. This number and other national sources of information can be found at the end of this section.

A report of child abuse is to be made to the state hotline number immediately upon discovery. They in turn will notify the appropriate county agency who will be in touch with you in the future. This is done via a verbal report and followed upon within 48 hours by the submission of a suspected *Child Abuse Form.* In Pennsylvania the form number is CY 47, which should be available at the facility the student is working or can be obtained from a children and youth agency. In some cases more than one county office will work in conjunction with another during an investigation.

Privileged communication is referred to in the "Child Protective Services Law," Section 4(c). This section stipulates that confidentiality does not apply to situations involving child abuse and this cannot be used as an excuse for failure to report. Issues regarding confidentiality should be dealt with during the first counseling session. During this phase of the counseling relationship, the client(s) become(s) aware of the counselors' ethical and legal obligations regarding the reporting of suspected child abuse. Thus, if such a report becomes necessary the client(s) has already been "forewarned." In such instances, the belief is that the damage to the therapeutic relationship can be kept at a minimum. This is further facilitated by encouraging the suspected perpetrators, if they are involved in counseling sessions with you, to call children and youth authorities themselves to report the incident. This is only possible when they have admitted to such.

If the client does not feel comfortable placing the call to the appropriate agency, the counselor can arrange for an immediate appointment with children and youth authorities and offer to attend the session with the client. Cooperation from the alleged perpetrator is ideal and facilitates behavioral change; however, if the client refuses to voluntarily participate in reporting, the student counselor has the responsibility to do so. This is also true when the perpetrator is not in counseling and the victim is. In some instances, the counselor may choose to involve the perpetrator at the time of the report; however, this becomes an individual issue which is best discussed with the field supervisor.

Regardless of the manner in which the reporting is done, time is of the essence. Abuse and/or neglect must be reported immediately to insure the safety of the alleged victim. Children and youth authorities will require some basic information during the initial oral report. A sample (Sample 8) of the required information a student should have prior to calling the authorities can be found at the end of this section. According to Schroeder (1979), two cases occurred in the state of California where a professional, a physician, was held liable in a civil suit for allowing children to return to their parents' care without reporting suspected child abuse. This occurred when the children were subsequently injured by the parents. Both cases serve as precedents for liability in not reporting suspected child abuse.

### Counseling Relationship

Dealing with child abuse is not easy for the counselor. Muehlemann and Kimmons (1981) addressed the difficulties psychologists have in making decisions regarding child abuse reporting. Often times this is due to the impact reporting will have on the counseling relationship.

What happens to the counseling relationship after a report of suspected child abuse is made to the authorities is dependent upon what happened during the counseling prior to the report. If mandatory reporting as it relates to the breach of confidentiality was discussed with clients when counseling was initiated, the likelihood of the continuance of a trusting relationship is enhanced. The same is also true when the counselor is supportive to client(s) during this process.

The degree of support afforded the client, whether perpetrator and/or victim, is very crucial in child abuse cases. More often than not, the degree of empathy a counselor has in this situation is a culmination of education, experience, and the counselor's personal values. Although a counselor's personal values are not to enter actively into the counseling relationship, in many ways they do indirectly. During the learning process, the student counselor needs to become aware of his/her own value system and evaluate, with the cooperation of the field instructor, how it impacts the counseling relationship. As Lippitt (1985) pointed out, counselors cannot function value free. The secret lies in not imposing one's values on others. If you do not feel comfortable dealing with these issues, which at times become quite

# A SAMPLE FOR CHILD ABUSE REPORTING

Practicum Counselor and Position

Date and Time

Alleged Perpetrator d.o.b.

Address S.S. #

Alleged Victim d.o.b.

Address S.S. #

Information obtained from d.o.b.

Address

Relationship to alleged perpetrator

Relationship to alleged victim

Brief description of incident or concern

Incident(s) ongoing or specific date

Reported to immediate supervisor on

Supervisor's name and position

Reported to children and youth on

time

Children and youth worker name

Alleged perpetrator aware of report? Yes No

Alleged victim aware of report? Yes No

Alleged perpetrator in counseling? Yes No

Where

Alleged victim in counseling? Yes No

Where

Results

Signature Student Counselor

Signature Field Supervisor

CC. Clients File
Agency File

**Sample 8.** A sample for child abuse reporting

# CHILD ABUSE AND NEGLECT SOCIAL SERVICE AGENCIES

## Hotline

Childline .................... 800-932-0313

## Resources

National Committee for the
Prevention of Child Abuse
P.O. Box 2866
Chicago, IL 60690 .................... 312-663-3520

Child Welfare Resource
Information Exchange
2011 I Street, NW
Suite 501
Washington, DC 20006 .................... 202-331-0028

Parents Anonymous
6733 S. Sepulveda Boulevard
Los Angeles, CA 90045 .................... 800-421-0353

Childhelp U.S.A.
P.O. Box 630
Hollywood, CA 90028 .................... 800-422-4453

International Society for the Prevention
of Child Abuse and Neglect
1205 Oneida Street
Denver, CO 80220 .................... 303-321-3963

Child Welfare League of America
67 Irving Place
New York, NY 10003 .................... 212-254-7410

National Child Abuse Coalition
1125 15th Street
Suite 300
Washington, DC 20005 .................... 202-293-7550

emotional, be honest with yourself and your field supervisor. Enlist his/her assistance in learning how to participate in this type of counseling. The victim and/or the perpetrator are your clients. You have ethical and legal responsibilities to them.

In the future, pay close attention to changing legislation regarding child abuse. The need for doing so can be illustrated by what presently exists in Pennsylvania. It is currently one of five states ineligible for funding by the National Center on Child Abuse and Neglect. Part of the reason for this is that the definition of child abuse is considered too narrow. State Attorney General LeRoy Zimmerman's Family Violence Task Force is recommending 37 revisions in the "Child Protective Services Law," criminal codes and child abuse agency policies. If the recommendations are adapted, the Pennsylvania laws may be more consistent with child abuse laws in other states. These changes are being suggested in an attempt to stem abuse ("Child Abuse," 1987).

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## NOTES

## CHAPTER 9

# FINAL EVALUATION

The preceding chapters in this text were primarily addressed to facilitating a student's process through the practicum/internship experience. Theoretical aspects integral to the counselor's training were integrated with various forms and sample formats in order to maximize the learning process for practicum student and interns.

This chapter is organized to aid those involved in the practicum/internship to formally evaluate it. This process will help practicum students and interns to determine their strengths and weaknesses. It also serves as a vehicle to help site personnel to formally evaluate their training structures.

The *Monthly Practicum Log* (Chapters 2, Form 2.6) permits the student to quantify the number of hours spent in particular counseling areas while in the practicum. The practicum student should detail the time spent in the various training activities. The student should have his/her supervisor sign the practicum log monthly in recognition of these activities.

The function of the remaining evaluation forms is explained in the information that follows. These forms are included at the end of this chapter.

The *Internship Log* (Form 9.1) parallels the function of the practicum log and is used by interns.

The *Student Evaluation Form* (9.2) complements the practicum and internship logs. The supervisor utilizes these forms to evaluate the student's work in each relevant and appropriate category.

The *Client's Personal-Social Satisfaction with Counseling* (Form 9.3) allows the practicum student's or intern's clients to address the degree of satisfaction experienced during the counseling process. The student should have his/her client sign and fill out the form when counseling has been terminated.

The *Student Counselor Evaluation of Supervisor* (Form 9.4) is filled out by practicum student or intern at the mid-point and conclusion of their supervisory contract. Both the student and his/her supervisor should sign the form.

A *Site Evaluation* (Form 9.5) is to be used so that site personnel and university program faculty can assess the quality of their training sites.

# NOTES

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the University Internship Coordinator at the completion of the internship.

| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

Form 9.1, p.1 of 1, Copy 1

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the University Internship Coordinator at the completion of the internship.

| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the University Internship Coordinator at the completion of the internship.

| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the University Internship Coordinator at the completion of the internship.

| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

3.0

## INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the University Internship Coordinator at the completion of the internship.

| ACTIVITIES | Week 1 from: to: | Week 2 from: to: | Week 3 from: to: | Week 4 from: to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

Form 9.1, p.1 of 1, Copy 5

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity and indicate the total in the monthly totals column.
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| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

Form 9.1, p.1 of 1, Copy 6

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week in each activity under the appropriate column.
3. Total the number of hours for the week and indicate at the bottom of the week column.
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| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

Form 9.1, p.1 of 1, Copy 7

# INTERNSHIP LOG

**DIRECTIONS**:

1. Record the dates of each week at the site where indicated.
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| ACTIVITIES | Week 1<br>from:<br>to: | Week 2<br>from:<br>to: | Week 3<br>from:<br>to: | Week 4<br>from:<br>to: | Monthly Totals |
|---|---|---|---|---|---|
| Intake Interview | | | | | |
| Individual Counseling | | | | | |
| Group Counseling | | | | | |
| Family Counseling | | | | | |
| Consulting /Intervention | | | | | |
| Psycho-Education | | | | | |
| Community Work | | | | | |
| Career Counseling | | | | | |
| Report Writing | | | | | |
| Case Conference | | | | | |
| Supervision<br>peer<br>individual<br>group | | | | | |
| Other | | | | | |
| Weekly Totals | | | | | |

Intern's Name

Supervisor's Signature

Form 9.1, p.1 of 1, Copy 8

# STUDENT EVALUATION

**DIRECTIONS:** Site supervisor is to complete this form in duplicate. One copy is to the student; the other copy is sent to the faculty liaison.

---

The areas listed below serve as a general guide for the activities typically engaged in during counselor/psychologist training. Please rate the student on the activities in which he/she has engaged using the following scale.

**A**--Functions extremely well and/or independently
**B**--Functions adequately and/or requires occasional supervision.
**C**--Requires close supervision in this area.
**NA**--Not applicable to this training experience.

---

| | |
|---|---|
| Student Name | Supervisor Signature |
| Site | Date |

## TRAINING ACTIVITIES

_____ 1. Intake Interviewing

_____ 2. Individual Counseling/Psychotherapy

_____ 3. Group Counseling/Psychotherapy

_____ 4. Testing: Administration and Interpretation

_____ 5. Report Writing

_____ 6. Consultation

_____ 7. Psycho/Educational Activities

_____ 8. Career Counseling

_____ 9. Family/Couple Counseling

_____ 10. Case Conference/Staff Presentation

_____ 11. Other (please list) _____

Compared with other graduate students in counseling at this level of training and experience, this student performs **overall** at the following level (check) one:

☐ 99th %ile ☐ 80th %ile ☐ 60th %ile ☐ 40th %ile ☐ 20th %ile

**Additional Comment:**

Please use the additional space for any comments that would help us to evaluate this student's progress. Student may comment upon exceptions to ratings, if any.

# STUDENT EVALUATION

**DIRECTIONS:** Site supervisor is to complete this form in duplicate. One copy is to the student; the other copy is sent to the faculty liaison.

---

The areas listed below serve as a general guide for the activities typically engaged in during counselor/psychologist training. Please rate the student on the activities in which he/she has engaged using the following scale.

**A**--Functions extremely well and/or independently
**B**--Functions adequately and/or requires occasional supervision.
**C**--Requires close supervision in this area.
**NA**--Not applicable to this training experience.

---

| | |
|---|---|
| ______________________ | ______________________ |
| Student Name | Supervisor Signature |
| ______________________ | ______________________ |
| Site | Date |

## TRAINING ACTIVITIES

________ 1. Intake Interviewing

________ 2. Individual Counseling/Psychotherapy

________ 3. Group Counseling/Psychotherapy

________ 4. Testing: Administration and Interpretation

________ 5. Report Writing

________ 6. Consultation

________ 7. Psycho/Educational Activities

________ 8. Career Counseling

________ 9. Family/Couple Counseling

________ 10. Case Conference/Staff Presentation

________ 11. Other (please list) ______________________

______________________

______________________

______________________

Compared with other graduate students in counseling at this level of training and experience, this student performs **overall** at the following level (check) one:

☐ 99th %ile ☐ 80th %ile ☐ 60th %ile ☐ 40th %ile ☐ 20th %ile

**Additional Comment:**

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3.8

# STUDENT EVALUATION

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**A**--Functions extremely well and/or independently
**B**--Functions adequately and/or requires occasional supervision.
**C**--Requires close supervision in this area.
**NA**--Not applicable to this training experience.

Student Name ____________________

Supervisor Signature ____________________

Site ____________________

Date ____________________

**TRAINING ACTIVITIES**

____ 1. Intake Interviewing
____ 2. Individual Counseling/Psychotherapy
____ 3. Group Counseling/Psychotherapy
____ 4. Testing: Administration and Interpretation
____ 5. Report Writing
____ 6. Consultation
____ 7. Psycho/Educational Activities
____ 8. Career Counseling
____ 9. Family/Couple Counseling
____ 10. Case Conference/Staff Presentation
____ 11. Other (please list) ____________________

Compared with other graduate students in counseling at this level of training and experience, this student performs **overall** at the following level (check) one:

☐ 99th %ile ☐ 80th %ile ☐ 60th %ile ☐ 40th %ile ☐ 20th %ile

**Additional Comment:**

Please use the additional space for any comments that would help us to evaluate this student's progress. Student may comment upon exceptions to ratings, if any.

## STUDENT EVALUATION

**DIRECTIONS:** Site supervisor is to complete this form in duplicate. One copy is to the student; the other copy is sent to the faculty liaison.

The areas listed below serve as a general guide for the activities typically engaged in during counselor/psychologist training. Please rate the student on the activities in which he/she has engaged using the following scale.

**A**--Functions extremely well and/or independently
**B**--Functions adequately and/or requires occasional supervision.
**C**--Requires close supervision in this area.
**NA**--Not applicable to this training experience.

______________________ Student Name
______________________ Supervisor Signature
______________________ Site
______________________ Date

### TRAINING ACTIVITIES

________ 1. Intake Interviewing
________ 2. Individual Counseling/Psychotherapy
________ 3. Group Counseling/Psychotherapy
________ 4. Testing: Administration and Interpretation
________ 5. Report Writing
________ 6. Consultation
________ 7. Psycho/Educational Activities
________ 8. Career Counseling
________ 9. Family/Couple Counseling
________ 10. Case Conference/Staff Presentation
________ 11. Other (please list) ______________________

______________________

______________________

______________________

Compared with other graduate students in counseling at this level of training and experience, this student performs **overall** at the following level (check) one:

☐ 99th %ile ☐ 80th %ile ☐ 60th %ile ☐ 40th %ile ☐ 20th %ile

**Additional Comment:**

Please use the additional space for any comments that would help us to evaluate this student's progress. Student may comment upon exceptions to ratings, if any.

# CLIENT'S PERSONAL-SOCIAL SATISFACTION WITH COUNSELING

Client Name ______________________ Counselor Name ______________________

Client ID Number ____________________ Counselor ID Number ____________________

Date ______________

Please read each of the following questions carefully and **circle** the response for each one that most nearly reflects your honest opinion.

1. How much help did you get with your concern?
   1 None
   2 A little
   3 Some
   4 Much
   5 All I needed

2. How satisfied are you with the relationship with your counselor?
   1 Not at all
   2 Slightly
   3 Some
   4 Pretty well
   5 Completely

3. How much help have you received with concerns other than your original reasons for entering counseling?
   1 None
   2 Little
   3 Some
   4 Much
   5 All I needed

4. How do you feel now compared to when you first came to counseling?
   1 Much worse
   2 A little worse
   3 The same
   4 Quite a bit
   5 Greatly

5. How much has counseling helped you in understanding yourself?
   1 None
   2 A little
   3 Moderately
   4 Quite a bit
   5 Greatly

6. How willing would you be to return to your counselor if you wanted help with another concern?
   1 Unwilling
   2 Reluctant
   3 Slightly inclined
   4 Moderately
   5 Very willing

7. How willing would you be to reccomend your counselor to one of your friends?
   1 Unwilling
   2 Reluctant
   3 Slightly inclined
   4 Moderately willing
   5 Very willing

---

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| | |
|---|---|
| 8. How much did your counselor differ from what you might consider to be an ideal counselor? | 1 Greatly<br>2 In many ways<br>3 Somewhat<br>4 A little<br>5 Not at all |
| 9. Based on your experiences at this clinic, how did you judge the counselors to be? | 1 Incompetent<br>2 Little competence<br>3 Moderately competent<br>4 Competent<br>5 Highly competent |
| 10. To what extent could the relationship you had with your counselor have been improved? | 1 Greatly<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 11. How sensitive was your counselor to the way you felt? | 1 Insensitive<br>2 Slighly sensitive<br>3 Sometimes insensitive<br>4 Usually sensitive<br>5 Very sensitive |
| 12. To what extent do you still lack self-understanding about the things that trouble you? | 1 Great<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns? | 1 I would not return<br>2 It would be unlikely for me to return<br>3 I might return<br>4 I probably would return<br>5 I would return |
| 14. In general, how satisfied are you with your counseling experience? | 1 Not satisfied<br>2 Moderately dissatisfied<br>3 Slightly satisfied<br>4 Moderately satisfied<br>5 Completely satisfied |
| 15. The technique most used by your counselor was? | 1 Left it to me<br>2 Interested listener<br>3 Gave opinions and suggestions<br>4 Gave interpretations<br>5 Counselor was vague & unclear |
| 16. Your reaction while being counseled. | 1 found it unpleasant and upsetting at times<br>2 found it very interesting, enjoyed it<br>3 I got angry often at my counselor<br>4 often felt discouraged at lack of progress.<br>5 felt relaxed and looked forward to sessions<br>6 felt that I could not get my story across, that I couldn't get counselor to understand me |

# CLIENT'S PERSONAL-SOCIAL SATISFACTION WITH COUNSELING

Client Name ____________________ Counselor Name ____________________

Client ID Number ____________________ Counselor ID Number ____________________

Date ____________

Please read each of the following questions carefully and **circle** the response for each one that most nearly reflects your honest opinion.

1. How much help did you get with your concern?

1 None
2 A little
3 Some
4 Much
5 All I needed

2. How satisfied are you with the relationship with your counselor?

1 Not at all
2 Slightly
3 Some
4 Pretty well
5 Completely

3. How much help have you received with concerns other than your original reasons for entering counseling?

1 None
2 Little
3 Some
4 Much
5 All I needed

4. How do you feel now compared to when you first came to counseling?

1 Much worse
2 A little worse
3 The same
4 Quite a bit
5 Greatly

5. How much has counseling helped you in understanding yourself?

1 None
2 A little
3 Moderately
4 Quite a bit
5 Greatly

6. How willing would you be to return to your counselor if you wanted help with another concern?

1 Unwilling
2 Reluctant
3 Slightly inclined
4 Moderately
5 Very willing

7. How willing would you be to reccomend your counselor to one of your friends?

1 Unwilling
2 Reluctant
3 Slightly inclined
4 Moderately willing
5 Very willing

---

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8. How much did your counselor differ from what you might consider to be an ideal counselor?

1 Greatly
2 In many ways
3 Somewhat
4 A little
5 Not at all

9. Based on your experiences at this clinic, how did you judge the counselors to be?

1 Incompetent
2 Little competence
3 Moderately competent
4 Competent
5 Highly competent

10. To what extent could the relationship you had with your counselor have been improved?

1 Greatly
2 Quite a bit
3 Moderately
4 Slightly
5 Not at all

11. How sensitive was your counselor to the way you felt?

1 Insensitive
2 Slighly sensitive
3 Sometimes insensitive
4 Usually sensitive
5 Very sensitive

12. To what extent do you still lack self-understanding about the things that trouble you?

1 Great
2 Quite a bit
3 Moderately
4 Slightly
5 Not at all

13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns?

1 I would not return
2 It would be unlikely for me to return
3 I might return
4 I probably would return
5 I would return

14. In general, how satisfied are you with your counseling experience?

1 Not satisfied
2 Moderately dissatisfied
3 Slightly satisfied
4 Moderately satisfied
5 Completely satisfied

15. The technique most used by your counselor was?

1 Left it to me
2 Interested listener
3 Gave opinions and suggestions
4 Gave interpretations
5 Counselor was vague & unclear

16. Your reaction while being counseled.

1 found it unpleasant and upsetting at times
2 found it very interesting, enjoyed it
3 I got angry often at my counselor
4 often felt discouraged at lack of progress.
5 felt relaxed and looked forward to sessions
6 felt that I could not get my story across, that I couldn't get counselor to understand me

# CLIENT'S PERSONAL-SOCIAL SATISFACTION WITH COUNSELING

Client Name ____________________ Counselor Name ____________________

Client ID Number ____________________ Counselor ID Number ____________________

Date ______________

Please read each of the following questions carefully and **circle** the response for each one that most nearly reflects your honest opinion.

1. How much help did you get with your concern?

   1 None
   2 A little
   3 Some
   4 Much
   5 All I needed

2. How satisfied are you with the relationship with your counselor?

   1 Not at all
   2 Slightly
   3 Some
   4 Pretty well
   5 Completely

3. How much help have you received with concerns other than your original reasons for entering counseling?

   1 None
   2 Little
   3 Some
   4 Much
   5 All I needed

4. How do you feel now compared to when you first came to counseling?

   1 Much worse
   2 A little worse
   3 The same
   4 Quite a bit
   5 Greatly

5. How much has counseling helped you in understanding yourself?

   1 None
   2 A little
   3 Moderately
   4 Quite a bit
   5 Greatly

6. How willing would you be to return to your counselor if you wanted help with another concern?

   1 Unwilling
   2 Reluctant
   3 Slightly inclined
   4 Moderately
   5 Very willing

7. How willing would you be to reccomend your counselor to one of your friends?

   1 Unwilling
   2 Reluctant
   3 Slightly inclined
   4 Moderately willing
   5 Very willing

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| | |
|---|---|
| 8. How much did your counselor differ from what you might consider to be an ideal counselor? | 1 Greatly<br>2 In many ways<br>3 Somewhat<br>4 A little<br>5 Not at all |
| 9. Based on your experiences at this clinic, how did you judge the counselors to be? | 1 Incompetent<br>2 Little competence<br>3 Moderately competent<br>4 Competent<br>5 Highly competent |
| 10. To what extent could the relationship you had with your counselor have been improved? | 1 Greatly<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 11. How sensitive was your counselor to the way you felt? | 1 Insensitive<br>2 Slighly sensitive<br>3 Sometimes insensitive<br>4 Usually sensitive<br>5 Very sensitive |
| 12. To what extent do you still lack self-understanding about the things that trouble you? | 1 Great<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns? | 1 I would not return<br>2 It would be unlikely for me to return<br>3 I might return<br>4 I probably would return<br>5 I would return |
| 14. In general, how satisfied are you with your counseling experience? | 1 Not satisfied<br>2 Moderately dissatisfied<br>3 Slightly satisfied<br>4 Moderately satisfied<br>5 Completely satisfied |
| 15. The technique most used by your counselor was? | 1 Left it to me<br>2 Interested listener<br>3 Gave opinions and suggestions<br>4 Gave interpretations<br>5 Counselor was vague & unclear |
| 16. Your reaction while being counseled. | 1 found it unpleasant and upsetting at times<br>2 found it very interesting, enjoyed it<br>3 I got angry often at my counselor<br>4 often felt discouraged at lack of progress.<br>5 felt relaxed and looked forward to sessions<br>6 felt that I could not get my story across, that I couldn't get counselor to understand me |

# CLIENT'S PERSONAL-SOCIAL SATISFACTION WITH COUNSELING

Client Name ____________________ Counselor Name ____________________

Client ID Number ____________________ Counselor ID Number ____________________

Date ____________

Please read each of the following questions carefully and **circle** the response for each one that most nearly reflects your honest opinion.

| | |
|---|---|
| 1. How much help did you get with your concern? | 1 None<br>2 A little<br>3 Some<br>4 Much<br>5 All I needed |
| 2. How satisfied are you with the relationship with your counselor? | 1 Not at all<br>2 Slightly<br>3 Some<br>4 Pretty well<br>5 Completely |
| 3. How much help have you received with concerns other than your original reasons for entering counseling? | 1 None<br>2 Little<br>3 Some<br>4 Much<br>5 All I needed |
| 4. How do you feel now compared to when you first came to counseling? | 1 Much worse<br>2 A little worse<br>3 The same<br>4 Quite a bit<br>5 Greatly |
| 5. How much has counseling helped you in understanding yourself? | 1 None<br>2 A little<br>3 Moderately<br>4 Quite a bit<br>5 Greatly |
| 6. How willing would you be to return to your counselor if you wanted help with another concern? | 1 Unwilling<br>2 Reluctant<br>3 Slightly inclined<br>4 Moderately<br>5 Very willing |
| 7. How willing would you be to reccomend your counselor to one of your friends? | 1 Unwilling<br>2 Reluctant<br>3 Slightly inclined<br>4 Moderately willing<br>5 Very willing |

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2 In many ways
3 Somewhat
4 A little
5 Not at all

9. Based on your experiences at this clinic, how did you judge the counselors to be?

1 Incompetent
2 Little competence
3 Moderately competent
4 Competent
5 Highly competent

10. To what extent could the relationship you had with your counselor have been improved?

1 Greatly
2 Quite a bit
3 Moderately
4 Slightly
5 Not at all

11. How sensitive was your counselor to the way you felt?

1 Insensitive
2 Slighly sensitive
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12. To what extent do you still lack self-understanding about the things that trouble you?

1 Great
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13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns?

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5 I would return

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2 Moderately dissatisfied
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4 Moderately satisfied
5 Completely satisfied

15. The technique most used by your counselor was?

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3 Gave opinions and suggestions
4 Gave interpretations
5 Counselor was vague & unclear

16. Your reaction while being counseled.

1 found it unpleasant and upsetting at times
2 found it very interesting, enjoyed it
3 I got angry often at my counselor
4 often felt discouraged at lack of progress.
5 felt relaxed and looked forward to sessions
6 felt that I could not get my story across, that I couldn't get counselor to understand me

## CLIENT'S PERSONAL-SOCIAL SATISFACTION WITH COUNSELING

Client Name ______________________ Counselor Name ______________________

Client ID Number ______________________ Counselor ID Number ______________________

Date ______________

Please read each of the following questions carefully and **circle** the response for each one that most nearly reflects your honest opinion.

1. How much help did you get with your concern?

1 None
2 A little
3 Some
4 Much
5 All I needed

2. How satisfied are you with the relationship with your counselor?

1 Not at all
2 Slightly
3 Some
4 Pretty well
5 Completely

3. How much help have you received with concerns other than your original reasons for entering counseling?

1 None
2 Little
3 Some
4 Much
5 All I needed

4. How do you feel now compared to when you first came to counseling?

1 Much worse
2 A little worse
3 The same
4 Quite a bit
5 Greatly

5. How much has counseling helped you in understanding yourself?

1 None
2 A little
3 Moderately
4 Quite a bit
5 Greatly

6. How willing would you be to return to your counselor if you wanted help with another concern?

1 Unwilling
2 Reluctant
3 Slightly inclined
4 Moderately
5 Very willing

7. How willing would you be to reccomend your counselor to one of your friends?

1 Unwilling
2 Reluctant
3 Slightly inclined
4 Moderately willing
5 Very willing

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| 9. Based on your experiences at this clinic, how did you judge the counselors to be? | 1 Incompetent<br>2 Little competence<br>3 Moderately competent<br>4 Competent<br>5 Highly competent |
| 10. To what extent could the relationship you had with your counselor have been improved? | 1 Greatly<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 11. How sensitive was your counselor to the way you felt? | 1 Insensitive<br>2 Slighly sensitive<br>3 Sometimes insensitive<br>4 Usually sensitive<br>5 Very sensitive |
| 12. To what extent do you still lack self-understanding about the things that trouble you? | 1 Great<br>2 Quite a bit<br>3 Moderately<br>4 Slightly<br>5 Not at all |
| 13. If counseling were available only on a fee-paying basis, how likely would you be to return if you had other concerns? | 1 I would not return<br>2 It would be unlikely for me to return<br>3 I might return<br>4 I probably would return<br>5 I would return |
| 14. In general, how satisfied are you with your counseling experience? | 1 Not satisfied<br>2 Moderately dissatisfied<br>3 Slightly satisfied<br>4 Moderately satisfied<br>5 Completely satisfied |
| 15. The technique most used by your counselor was? | 1 Left it to me<br>2 Interested listener<br>3 Gave opinions and suggestions<br>4 Gave interpretations<br>5 Counselor was vague & unclear |
| 16. Your reaction while being counseled. | 1 found it unpleasant and upsetting at times<br>2 found it very interesting, enjoyed it<br>3 I got angry often at my counselor<br>4 often felt discouraged at lack of progress.<br>5 felt relaxed and looked forward to sessions<br>6 felt that I could not get my story across, that I couldn't get counselor to understand me |

# STUDENT COUNSELOR EVALUATION OF SUPERVISOR*

**SUGGESTED USE:** The practicum or internship supervisor could obtain feedback on the supervision by asking student counselors to complete this form. The evaluation could be done at mid-term and/or final. The purposes are twofold: (1) to provide feedback for improving supervision and (2) to encourage communication between the supervisor and the student counselor.

Name of Practicum or Internship Supervisor ____________________

Period covered ____________________ to ____________________

**DIRECTIONS:** The student counselor when asked to do so is to make an evaluation of the supervision received. Circle the number which best represents how you, the student counselor, feel about the supervision received. After the form is completed, the supervisor may suggest a meeting to discuss the supervision desired.

| | Poor | Adequate | Good |
|---|---|---|---|
| 1. Gives time and energy in observing, tape processing and case conferences | 1 2 | 3 4 | 5 6 |
| 2. Accepts and respects me as a person. | 1 2 | 3 4 | 5 6 |
| 3. Recognizes and encourages further development of my strengths and capabilities. | 1 2 | 3 4 | 5 6 |
| 4. Gives me useful feedback when I do something well. | 1 2 | 3 4 | 5 6 |
| 5. Provides me the freedom to develop flexible and effective counseling styles. | 1 2 | 3 4 | 5 6 |
| 6. Encourages and listens to my ideas and suggestions for developing my counseling skills. | 1 2 | 3 4 | 5 6 |
| 7. Provides suggestions for developing my counseling skills. | 1 2 | 3 4 | 5 6 |
| 8. Helps me to understand the implications and dynamics of the counseling approaches I use. | 1 2 | 3 4 | 5 6 |
| 9. Encourages me to use new and different techniques when appropriate. | 1 2 | 3 4 | 5 6 |
| 10. Is spontaneous and flexible in the supervisory sessions. | 1 2 | 3 4 | 5 6 |
| 11. Helps me to define and achieve specific concrete goals for myself during the practicum experience. | 1 2 | 3 4 | 5 6 |
| 12. Gives me useful feedback when I do something wrong. | 1 2 | 3 4 | 5 6 |

---

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| | | | | | | |
|---|---|---|---|---|---|---|
| 13. Allows me to discuss problems I encounter in my practicum setting. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. Pays amount of attention to both me and my clients. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. Focuses on both verbal and nonverbal behavior in me and in my clients. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. Helps me define and maintain ethical behavior in counseling and case management. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. Encourages me to engage in professional behavior. | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. Maintains confidentiality in material discussed in supervisory sessions. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. Deal with both content and effect when supervising. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. Focuses on the implications, consequences, and contingencies of specific behaviors in counseling and supervision. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. Helps me organize relevant case data in planning goals and strategies with my client. | 1 | 2 | 3 | 4 | 5 | 6 |
| 22. Helps me to formulate a theoretically sound rationale of human behavior. | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. Offers resource information when I request or need it. | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. Helps me develop increased skill in critiquing and gaining insight from my counseling tapes. | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. Allows and encourages me to evaluate myself. | 1 | 2 | 3 | 4 | 5 | 6 |
| 26. Explains his/her criteria for evaluation clearly and in behavioral terms. | 1 | 2 | 3 | 4 | 5 | 6 |
| 27. Applies his/her criteria fairly in evaluating my counseling performance. | 1 | 2 | 3 | 4 | 5 | 6 |

**ADDITIONAL COMMENTS AND/OR SUGGESTIONS**

______________________________________________

______________________________________________

______________ ______________________________

Date Practicum Student

My signature indicates that I have read the above report and have discussed the content with my supervisee. It does not necessarily indicate that I agree with the report in part or in whole.

______________ ______________________________

Date Signature of Supervisor

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| 25. Allows and encourages me to evaluate myself. | 1 2 | 3 4 | 5 6 |
| 26. Explains his/her criteria for evaluation clearly and in behavioral terms. | 1 2 | 3 4 | 5 6 |
| 27. Applies his/her criteria fairly in evaluating my counseling performance. | 1 2 | 3 4 | 5 6 |

## ADDITIONAL COMMENTS AND/OR SUGGESTIONS

________________________________________________________

________________________________________________________

________________ __________________________________

Date Practicum Student

My signature indicates that I have read the above report and have discussed the content with my supervisee. It does not necessarily indicate that I agree with the report in part or in whole.

________________ __________________________________

Date Signature of Supervisor

# SITE EVALUATION

**DIRECTIONS:** Student completes this form at the end of the practicum and/or internship. This should be turned in to the University supervisor or Internship coordinator as indicated by the University program.

---

Name ______________________ Site ______________________

Dates of Placement ______________________ Site Supervisor ______________________

Faculty Liaison ______________________

Rate the following questions about your site and experiences by the following:

- A. Very satisfactory
- B. Moderately satisfactory
- C. Moderately unsatisfactory
- D. Very unsatisfactory

1) ____ Amount of on-site supervision.

2) ____ Quality and usefulness of on-site supervision.

3) ____ Usefulness and helpfulness of faculty liaison.

4) ____ Relevance of experience to career goals.

5) ____ Exposure to and communication of school/agency goals.

6) ____ Exposure to and communication of school/agency procedures.

7) ____ Exposure to professional roles and functions within the school/agency.

8) ____ Exposure to information about community resources.

9) ____ Rate **all** applicable experiences which you had at your site:

- ____ Report writing
- ____ Intake interviewing
- ____ Administration and interpretation of tests
- ____ Staff presentations/case conferences
- ____ Individual counseling
- ____ Group counseling
- ____ Family/couple counseling
- ____ Psycho/Educational activities
- ____ Consultation
- ____ Career counseling
- ____ Other ______________________

10) ____ Overall evaluation of the site.

**COMMENTS:** Include any suggestions for improvements in the experiences you have rated moderately (C) or very unsatisfactory (D).

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---

Name ____________________ Site ____________________

Dates of Placement ____________________ Site Supervisor ____________________

Faculty Liaison ____________________

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A. Very satisfactory
B. Moderately satisfactory
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D. Very unsatisfactory

1) ____ Amount of on-site supervision.

2) ____ Quality and usefulness of on-site supervision.

3) ____ Usefulness and helpfulness of faculty liaison.

4) ____ Relevance of experience to career goals.

5) ____ Exposure to and communication of school/agency goals.

6) ____ Exposure to and communication of school/agency procedures.

7) ____ Exposure to professional roles and functions within the school/agency.

8) ____ Exposure to information about community resources.

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____ Report writing
____ Intake interviewing
____ Administration and interpretation of tests
____ Staff presentations/case conferences
____ Individual counseling
____ Group counseling
____ Family/couple counseling
____ Psycho/Educational activities
____ Consultation
____ Career counseling
____ Other ____________________

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**COMMENTS:** Include any suggestions for improvements in the experiences you have rated moderately (C) or very unsatisfactory (D).

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